Community Healthcare Coalition of Greater Prince William

Improving the health of the residents of the Greater Prince William Area

GREATER PRINCE WILLIAM AREA COMMUNITY HEALTH ASSESSMENT

(2016)

Adapted from: County Health Rankings and Roadmaps Action Cycle

Prince William Health District | SENTARA HEALTHCARE | GEORGE MASON UNIVERSITY | Greater Prince William Community Health Center | Potomac Health Foundation | NOVANT HEALTH | UVA HEALTH SYSTEM

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Executive Summary

Background

The Community Healthcare Coalition of Greater Prince William (CHCGPW) has developed the 2016 Greater Prince William Community Health Assessment. The CHCGPW is a partnership between George Mason University, the Greater Prince William Community Health Center, Kaiser Permanente, Novant UVA Health System, Potomac Health Foundation, Prince William Area Free Clinic, Prince William Health District, and Sentara Healthcare System, with the goal of collectively improving the health of the residents of the jurisdictions served by the participating entities. This community collaboration was established so that through shared resources and collective effort, a Community Health Assessment and Community Health Improvement Plan would be developed to prioritize community health issues and promote strategies to improve health outcomes.

Both qualitative and quantitative data was used to determine the most pressing public health issues in order to provide the foundation for the development of a comprehensive community health needs assessment, and to prioritize those issues to be tackled through a strategic planning process.

The 2016 Health Check Survey was distributed through various venues throughout the community. The purpose was to have residents assist in identifying in their opinion, the most pressing public health problems in the community in which they live. Nine hundred and eighteen surveys were analyzed, excluding those surveys without zip code identification, a zip code which was not in the defined service area, or more than two questions unanswered. In addition, each coalition member provided a list of community partners to send out a leadership survey, and requested that the respondent identify in their opinion important community public health problems. Fifty two respondents completed this survey. There were two Town Hall meetings, one on May 24, 2016 at the Northern Virginia Community College in Manassas, and one on June 6, 2016 at Sentara Northern Virginia Medical Center, in order to obtain community input regarding the survey results. These meetings provided important qualitative information and robust discussions.

The Community Health Assessment Plan will help guide the Community Health Improvement Plan. According to the Centers for Disease Control and Prevention (CDC), a Community Health

Improvement Plan is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process.

Collectively the CHCGPW will improve the health of the community by utilizing limited resources most effectively and efficiently to strategically improve community health outcomes for the identified priority public health issues.

Identified Community Health Needs

Analysis of the qualitative and quantitative data from the surveys and Town Hall meetings identified public health issues that were important to the community. When prioritizing the community needs, the coalition took into consideration whether through a facilitated community effort the coalition could impact the health concerns.

When the coalition analyzed the Leadership and Health Check survey data, the top ten priority public health issues were very similar. Additionally, some of the issues were felt to be related, and could be addressed together.

The three categories of public health needs identified were:

- Substance Use/Abuse and Mental Health Conditions
- Obesity, Access to Healthy Foods, and Physical Activity
- Access to Healthcare (included dental care)

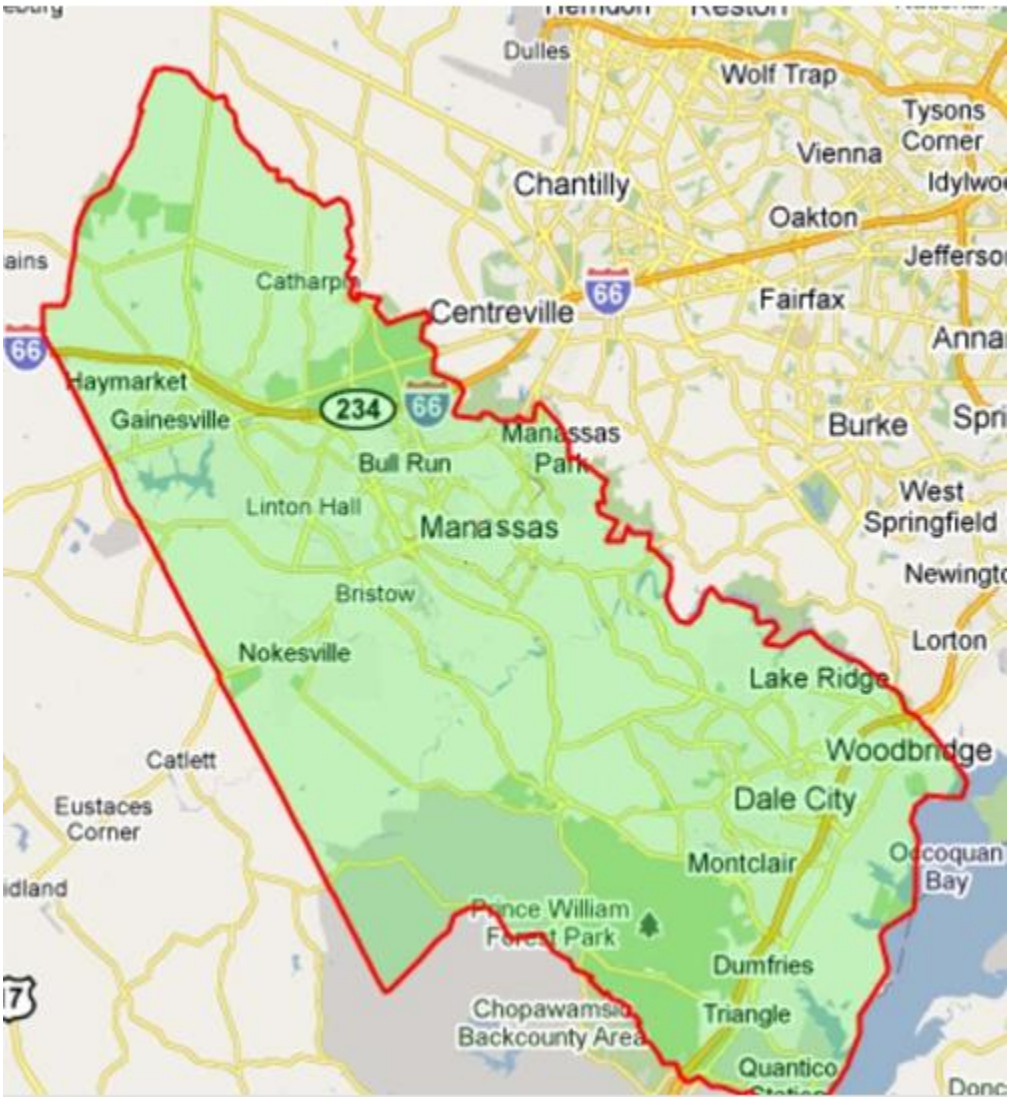
The coalition broke up into three groups to address each category by involving other knowledgeable community partners and analyzing primary and secondary data from various sources in order to better understand community strengths, weaknesses, gaps, trends, and target populations that impact these health issues.

Next Steps

The coalition will work together with community partners to better understand community health problems, prioritize health issues, inform decisions, and develop, implement, and evaluate a collective community health improvement effort. The 2016 Community Health Assessment and Community Health Improvement Plan will be available on various coalition members' websites.

Introduction

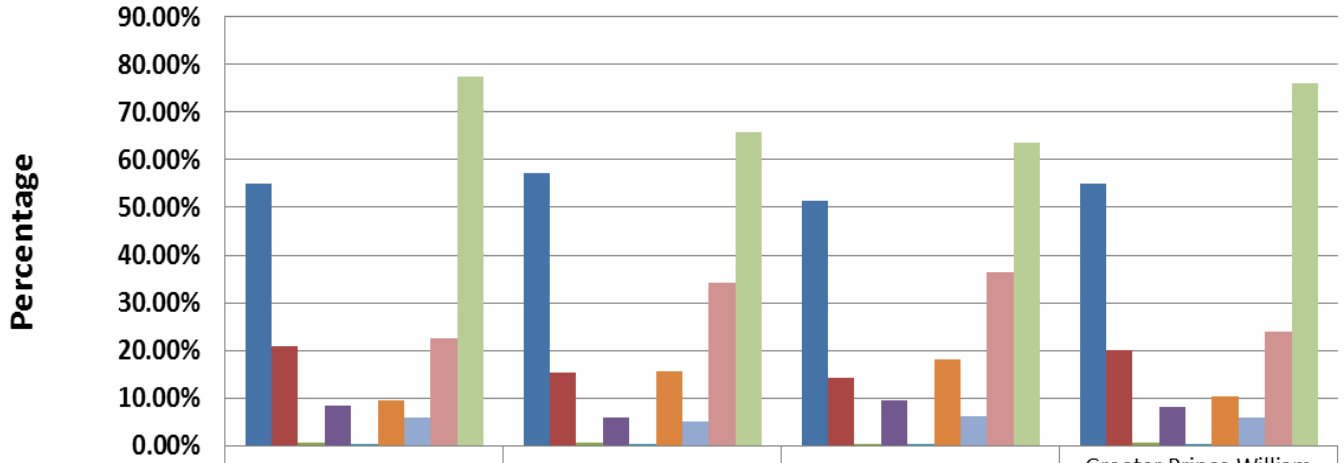
The Greater Prince William Health Area (GPWA) is located in Northern Virginia, approximately 35 miles southwest of Washington, D.C. The GPWA is part of the National Capital Region, which includes counties and cities in the Washington metropolitan area. GPWA encompasses a total area of 349 square miles and includes Prince William County and the independent cities of Manassas and Manassas Park. The community provides public health services to 513,484 residents with diverse cultural and ethnic backgrounds.



Greater Prince William Area Characteristics

- High percentage of children under the age of 18 and lower percentage of persons age 65 and over than Virginia.
- Median Age is in the thirties
- Nearly three times as many people of Hispanic origin than Virginia
- Twice as many residents that speak another language than English than Virginia
- Majority minority community
- Fewer households with an income less than $75,000 than Virginia, but also pockets of low income residents in the community.
- Prince William County (6.5%) and Manassas Park City (9.3%) have lower percent residents below the poverty level than Virginia (11.5%), but Manassas City (12.3%) has a higher percentage below the poverty level than Virginia.
- Substantially higher persons per square mile than Virginia
- Higher percentage of people in the armed forces than Virginia
- Greater mean travel time to work than Virginia
- Higher percentage of uninsured children and adults than Virginia

Racial/Ethnic Demographics-Greater Prince William Area



	Prince William County	Manassas City	Manassas Park City	Greater Prince William Area
White	54.90%	57.20%	51.50%	54.90%
Black	20.80%	15.20%	14.20%	20.10%
American Indian	0.62%	0.60%	0.45%	0.62%
Asian	8.29%	5.90%	9.60%	8.13%
Native Hawaiian/ Pacific Islander	0.15%	0.20%	0.10%	0.16%
Some Other Race	9.50%	15.70%	17.97%	10.30%
2+ Races	5.80%	5.10%	6.10%	5.90%
Hispanic/Latino	22.50%	34.10%	36.30%	23.80%
Not Hispanic/Latino	77.50%	65.90%	63.70%	76.20%

***Source**: Be Healthy Be Happy Prince William*

Non-English Languages Spoken at Home

Prince William County		Manassas City		Manassas Park City	
Spanish	18.0%	**Spanish**	28.6%	**Spanish**	31.5%
African	2.2%	**Tagalog**	0.9%	**Persian**	2.2%
Urdu	1.1%	**Vietnamese**	0.9%	**Vietnamese**	2.0%
Vietnamese	1.0%	**Arabic**	0.6%	**Other Slavic**	1.3%
Korean	0.9%	**Other Indic**	0.6%	**Korean**	1.1%
Tagalog	0.8%	**German**	0.5%	**Arabic**	1.0%
Other Indic	0.7%	**Portuguese**	0.5%	**Chinese**	0.9%
Arabic	0.7%	**African**	0.5%	**Tagalog**	0.8%
Persian	0.6%	**French**	0.4%	**Other Indic**	0.7%
Chinese	0.5%	**Other Asian**	0.3%	**Portuguese**	0.7%
French	0.4%	**Persian**	0.3%	**African**	0.5%
German	0.4%	**Korean**	0.3%	**Urdu**	0.5%
Other Indo-European	0.3%	**Russian**	0.2%	**Thai**	0.4%
Hindi	0.3%	**Gujarati**	0.2%	**Hindi**	0.3%
Other Asian	0.3%	**Hindi**	0.2%	**Laotian**	0.3%
Portuguese	0.2%	**Cambodian**	0.2%	**Russian**	0.1%
French Creole	0.2%	**Chinese**	0.2%	**French**	0.1%
Gujarati	0.2%	**Italian**	0.2%		
Other Pacific Island	0.1%	**Other Indo-European**	0.2%		
Russian	0.1%	**Japanese**	0.1%		

***Source**: Statistical Atlas*

Age Distribution

Subject	Prince William County, Virginia					
	Total		Male		Female	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	428,772	*****	213,427	+/-131	215,345	+/-131
AGE						
Under 5 years	8.1%	+/-0.1	8.3%	+/-0.1	7.9%	+/-0.1
5 to 9 years	8.4%	+/-0.2	8.7%	+/-0.3	8.2%	+/-0.3
10 to 14 years	7.5%	+/-0.2	7.7%	+/-0.3	7.3%	+/-0.3
15 to 19 years	6.9%	+/-0.1	7.2%	+/-0.1	6.7%	+/-0.1
20 to 24 years	6.3%	+/-0.1	6.5%	+/-0.1	6.1%	+/-0.1
25 to 29 years	6.9%	+/-0.1	7.0%	+/-0.1	6.9%	+/-0.1
30 to 34 years	7.8%	+/-0.1	7.7%	+/-0.1	7.9%	+/-0.1
35 to 39 years	7.7%	+/-0.2	7.7%	+/-0.3	7.8%	+/-0.4
40 to 44 years	8.0%	+/-0.3	7.9%	+/-0.4	8.1%	+/-0.3
45 to 49 years	7.8%	+/-0.1	7.8%	+/-0.1	7.9%	+/-0.1
50 to 54 years	7.1%	+/-0.1	7.1%	+/-0.1	7.1%	+/-0.1
55 to 59 years	5.4%	+/-0.2	5.5%	+/-0.2	5.2%	+/-0.2
60 to 64 years	4.5%	+/-0.2	4.2%	+/-0.2	4.8%	+/-0.2
65 to 69 years	3.0%	+/-0.1	2.9%	+/-0.1	3.1%	+/-0.2
70 to 74 years	2.0%	+/-0.1	1.7%	+/-0.1	2.2%	+/-0.2
75 to 79 years	1.1%	+/-0.1	1.0%	+/-0.1	1.3%	+/-0.1
80 to 84 years	0.7%	+/-0.1	0.6%	+/-0.1	0.8%	+/-0.1
85 years and over	0.7%	+/-0.1	0.5%	+/-0.1	0.9%	+/-0.1
SELECTED AGE CATEGORIES						
5 to 14 years	15.9%	+/-0.1	16.4%	+/-0.1	15.4%	+/-0.1
15 to 17 years	4.5%	+/-0.1	4.6%	+/-0.1	4.3%	+/-0.1
18 to 24 years	8.8%	+/-0.1	9.1%	+/-0.1	8.4%	+/-0.1
15 to 44 years	43.6%	+/-0.1	44.0%	+/-0.1	43.3%	+/-0.1
16 years and over	74.5%	+/-0.1	73.9%	+/-0.1	75.2%	+/-0.2
18 years and over	71.6%	*****	70.8%	+/-0.1	72.4%	+/-0.1
60 years and over	12.0%	+/-0.2	10.9%	+/-0.2	13.2%	+/-0.2
62 years and over	10.1%	+/-0.1	9.1%	+/-0.2	11.1%	+/-0.2
65 years and over	7.5%	+/-0.1	6.7%	+/-0.1	8.4%	+/-0.1
75 years and over	2.5%	+/-0.1	2.0%	+/-0.1	3.1%	+/-0.1
SUMMARY INDICATORS						
Median age (years)	33.7	+/-0.1	33.0	+/-0.2	34.5	+/-0.2
Sex ratio (males per 100 females)	99.1	+/-0.1	(X)	(X)	(X)	(X)
Age dependency ratio	56.1	+/-0.1	(X)	(X)	(X)	(X)
Old-age dependency ratio	11.7	+/-0.1	(X)	(X)	(X)	(X)
Child dependency ratio	44.4	+/-0.1	(X)	(X)	(X)	(X)

Source: U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics

Subject	Manassas city, Virginia					
	Total		Male		Female	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	40,436	*****	20,195	+/-103	20,241	+/-103
AGE						
Under 5 years	8.5%	*****	8.9%	+/-0.3	8.1%	+/-0.3
5 to 9 years	7.6%	+/-0.9	7.1%	+/-1.2	8.2%	+/-1.4
10 to 14 years	7.2%	+/-0.9	8.1%	+/-1.3	6.4%	+/-1.4
15 to 19 years	6.5%	+/-0.5	6.3%	+/-0.7	6.7%	+/-0.7
20 to 24 years	7.7%	+/-0.6	8.3%	+/-0.7	7.1%	+/-0.9
25 to 29 years	7.8%	+/-0.4	7.9%	+/-0.4	7.7%	+/-0.7
30 to 34 years	8.5%	+/-0.5	8.5%	+/-0.7	8.5%	+/-0.8
35 to 39 years	7.0%	+/-0.8	7.0%	+/-1.1	7.0%	+/-1.0
40 to 44 years	7.5%	+/-0.9	8.0%	+/-1.1	7.0%	+/-1.1
45 to 49 years	7.1%	+/-0.3	6.8%	+/-0.3	7.4%	+/-0.5
50 to 54 years	6.9%	+/-0.3	6.8%	+/-0.3	7.0%	+/-0.5
55 to 59 years	6.2%	+/-0.6	5.9%	+/-0.9	6.6%	+/-0.7
60 to 64 years	4.0%	+/-0.6	4.2%	+/-0.8	3.8%	+/-0.8
65 to 69 years	2.7%	+/-0.4	2.6%	+/-0.7	2.8%	+/-0.4
70 to 74 years	2.0%	+/-0.4	2.2%	+/-0.6	1.9%	+/-0.4
75 to 79 years	1.0%	+/-0.2	0.7%	+/-0.2	1.3%	+/-0.3
80 to 84 years	0.7%	+/-0.2	0.4%	+/-0.2	1.1%	+/-0.4
85 years and over	1.0%	+/-0.3	0.6%	+/-0.2	1.4%	+/-0.4
SELECTED AGE CATEGORIES						
5 to 14 years	14.9%	*****	15.2%	+/-0.3	14.6%	+/-0.3
15 to 17 years	4.3%	*****	3.9%	+/-0.3	4.6%	+/-0.3
18 to 24 years	9.9%	+/-0.5	10.7%	+/-0.4	9.2%	+/-0.8
15 to 44 years	45.0%	+/-0.2	45.9%	+/-0.4	44.0%	+/-0.3
16 years and over	75.5%	+/-0.3	74.8%	+/-0.6	76.2%	+/-0.5
18 years and over	72.4%	*****	72.0%	+/-0.4	72.7%	+/-0.4
60 years and over	11.5%	+/-0.6	10.6%	+/-0.8	12.3%	+/-0.7
62 years and over	10.1%	+/-0.5	9.2%	+/-0.8	10.9%	+/-0.5
65 years and over	7.5%	+/-0.4	6.4%	+/-0.7	8.5%	+/-0.3
75 years and over	2.7%	+/-0.2	1.6%	+/-0.1	3.8%	+/-0.4
SUMMARY INDICATORS						
Median age (years)	32.6	+/-0.4	31.3	+/-0.5	33.8	+/-0.6
Sex ratio (males per 100 females)	99.8	+/-1.0	(X)	(X)	(X)	(X)
Age dependency ratio	54.0	+/-0.9	(X)	(X)	(X)	(X)
Old-age dependency ratio	11.5	+/-0.7	(X)	(X)	(X)	(X)
Child dependency ratio	42.6	+/-0.3	(X)	(X)	(X)	(X)

Source: 2014 Data U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics

Subject	Manassas Park city, Virginia					
	Total		Male		Female	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	14,992	*****	7,572	+/-174	7,420	+/-174
AGE						
Under 5 years	6.7%	*****	8.0%	+/-1.5	5.5%	+/-1.6
5 to 9 years	9.0%	+/-1.5	7.3%	+/-1.8	10.8%	+/-2.2
10 to 14 years	6.5%	+/-1.4	7.1%	+/-1.8	5.8%	+/-2.0
15 to 19 years	6.3%	+/-0.7	6.8%	+/-1.6	5.7%	+/-1.7
20 to 24 years	6.2%	+/-0.6	7.2%	+/-0.9	5.2%	+/-1.0
25 to 29 years	9.2%	+/-0.7	8.7%	+/-0.9	9.8%	+/-1.0
30 to 34 years	11.1%	+/-1.4	10.5%	+/-1.2	11.7%	+/-2.2
35 to 39 years	6.8%	+/-1.6	7.3%	+/-2.7	6.2%	+/-1.7
40 to 44 years	9.7%	+/-1.6	8.6%	+/-2.3	10.8%	+/-2.3
45 to 49 years	7.4%	+/-1.3	9.5%	+/-2.1	5.2%	+/-0.9
50 to 54 years	6.2%	+/-0.9	5.9%	+/-0.9	6.5%	+/-1.3
55 to 59 years	4.9%	+/-1.1	4.8%	+/-1.3	5.0%	+/-1.7
60 to 64 years	3.5%	+/-0.9	2.9%	+/-1.2	4.1%	+/-1.4
65 to 69 years	2.3%	+/-0.7	2.5%	+/-1.1	2.2%	+/-1.1
70 to 74 years	2.1%	+/-0.6	1.8%	+/-0.6	2.5%	+/-1.1
75 to 79 years	1.6%	+/-0.7	0.9%	+/-0.7	2.4%	+/-1.3
80 to 84 years	0.4%	+/-0.3	0.4%	+/-0.5	0.4%	+/-0.4
85 years and over	0.1%	+/-0.1	0.0%	+/-0.4	0.1%	+/-0.2
SELECTED AGE CATEGORIES						
5 to 14 years	15.5%	+/-0.5	14.4%	+/-1.1	16.6%	+/-1.4
15 to 17 years	4.0%	+/-0.5	4.1%	+/-1.1	3.8%	+/-1.3
18 to 24 years	8.5%	+/-0.5	9.9%	+/-0.9	7.1%	+/-0.4
15 to 44 years	49.3%	+/-1.6	49.1%	+/-2.5	49.4%	+/-2.2
16 years and over	76.4%	+/-0.8	75.8%	+/-2.0	77.0%	+/-1.9
18 years and over	73.8%	*****	73.5%	+/-1.8	74.1%	+/-1.8
60 years and over	10.0%	+/-1.1	8.4%	+/-1.3	11.7%	+/-1.6
62 years and over	8.1%	+/-1.0	7.1%	+/-1.2	9.2%	+/-1.5
65 years and over	6.5%	+/-0.7	5.5%	+/-0.9	7.6%	+/-1.3
75 years and over	2.1%	+/-0.8	1.2%	+/-0.9	3.0%	+/-1.4
SUMMARY INDICATORS						
Median age (years)	32.9	+/-0.4	32.5	+/-0.7	33.2	+/-0.7
Sex ratio (males per 100 females)	102.0	+/-4.7	(X)	(X)	(X)	(X)
Age dependency ratio	48.7	+/-1.6	(X)	(X)	(X)	(X)
Old-age dependency ratio	9.7	+/-1.2	(X)	(X)	(X)	(X)
Child dependency ratio	39.0	+/-0.4	(X)	(X)	(X)	(X)

Source: 2014 Data U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics

Health Insurance Coverage

Civilian noninstitutionalized population	420,411	+/-948	420,411
With health insurance coverage	363,835	+/-2,771	86.5%
With private health insurance	325,284	+/-3,574	77.4%
With public coverage	69,568	+/-1,962	16.5%
No health insurance coverage	56,576	+/-2,527	13.5%
Civilian noninstitutionalized population under 18 years	121,805	+/-37	121,805
No health insurance coverage	8,261	+/-1,007	6.8%
Civilian noninstitutionalized population 18 to 64 years	266,870	+/-951	266,870
In labor force:	222,950	+/-1,404	222,950
Employed:	210,355	+/-1,566	210,355
With health insurance coverage	178,834	+/-2,004	85.0%
With private health insurance	175,789	+/-2,018	83.6%
With public coverage	7,820	+/-675	3.7%
No health insurance coverage	31,521	+/-1,801	15.0%
Unemployed:	12,595	+/-849	12,595
With health insurance coverage	7,389	+/-605	58.7%
With private health insurance	6,436	+/-580	51.1%
With public coverage	1,193	+/-252	9.5%
No health insurance coverage	5,206	+/-638	41.3%
Not in labor force:	43,920	+/-1,266	43,920
With health insurance coverage	33,443	+/-1,223	76.1%
With private health insurance	28,920	+/-1,104	65.8%
With public coverage	6,490	+/-649	14.8%
No health insurance coverage	10,477	+/-820	23.9%

Source: U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics

Poverty Data

Prince William County, Virginia
Individuals below poverty level
6.5%

Subject	Prince William County, Virginia					
	Total		Below poverty level		Percent below poverty level	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Population for whom poverty status is determined	423,575	+/-930	27,593	+/-2,476	6.5%	+/-0.6
AGE						
Under 18 years	120,450	+/-307	11,515	+/-1,357	9.6%	+/-1.1
Related children under 18 years	119,956	+/-403	11,032	+/-1,313	9.2%	+/-1.1
18 to 64 years	271,389	+/-861	15,040	+/-1,328	5.5%	+/-0.5
65 years and over	31,736	+/-183	1,038	+/-224	3.3%	+/-0.7
SEX						
Male	209,547	+/-817	12,166	+/-1,270	5.8%	+/-0.6
Female	214,028	+/-314	15,427	+/-1,514	7.2%	+/-0.7
RACE AND HISPANIC OR LATINO ORIGIN						
One race	401,114	+/-1,564	25,609	+/-2,312	6.4%	+/-0.6
White	263,007	+/-2,193	14,455	+/-1,798	5.5%	+/-0.7
Black or African American	84,845	+/-1,160	7,131	+/-1,099	8.4%	+/-1.3
American Indian and Alaska Native	1,224	+/-375	82	+/-66	6.7%	+/-5.5
Asian	32,654	+/-786	2,452	+/-775	7.5%	+/-2.4
Native Hawaiian and Other Pacific Islander	377	+/-133	0	+/-28	0.0%	+/-8.3
Some other race	19,007	+/-1,945	1,489	+/-589	7.8%	+/-2.9
Two or more races	22,461	+/-1,527	1,984	+/-573	8.8%	+/-2.6
Hispanic or Latino origin (of any race)	89,851	+/-208	9,674	+/-1,559	10.8%	+/-1.7
White alone, not Hispanic or Latino	198,923	+/-704	7,037	+/-959	3.5%	+/-0.5

Source: U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics
Source: 2010-2014 American Community Survey 5-Year Estimates

Manassas City, Virginia
Individuals below poverty level

12.3%

Subject	Manassas city, Virginia					
	Total		Below poverty level		Percent below poverty level	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Population for whom poverty status is determined	40,366	+/-44	4,953	+/-1,025	12.3%	+/-2.5
AGE						
Under 18 years	11,158	+/-24	2,119	+/-553	19.0%	+/-5.0
Related children under 18 years	11,087	+/-109	2,048	+/-549	18.5%	+/-4.9
18 to 64 years	26,231	+/-164	2,659	+/-568	10.1%	+/-2.2
65 years and over	2,977	+/-159	175	+/-70	5.9%	+/-2.4
SEX						
Male	20,156	+/-110	2,183	+/-514	10.8%	+/-2.5
Female	20,210	+/-105	2,770	+/-606	13.7%	+/-3.0
RACE AND HISPANIC OR LATINO ORIGIN						
One race	38,707	+/-432	4,624	+/-974	11.9%	+/-2.5
White	29,644	+/-625	3,820	+/-931	12.9%	+/-3.1
Black or African American	5,850	+/-387	591	+/-339	10.1%	+/-5.8
American Indian and Alaska Native	43	+/-51	31	+/-46	72.1%	+/-57.5
Asian	2,052	+/-196	30	+/-29	1.5%	+/-1.4
Native Hawaiian and Other Pacific Islander	0	+/-25	0	+/-25	-	**
Some other race	1,118	+/-494	152	+/-157	13.6%	+/-14.4
Two or more races	1,659	+/-427	329	+/-248	19.8%	+/-13.8
Hispanic or Latino origin (of any race)	13,127	+/-4	2,976	+/-905	22.7%	+/-6.9
White alone, not Hispanic or Latino	18,366	+/-112	1,072	+/-310	5.8%	+/-1.7

Source: U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics

Source: 2010-2014 American Community Survey 5-Year Estimates

Manassas Park City, Virginia
Individuals below poverty level

9.3%

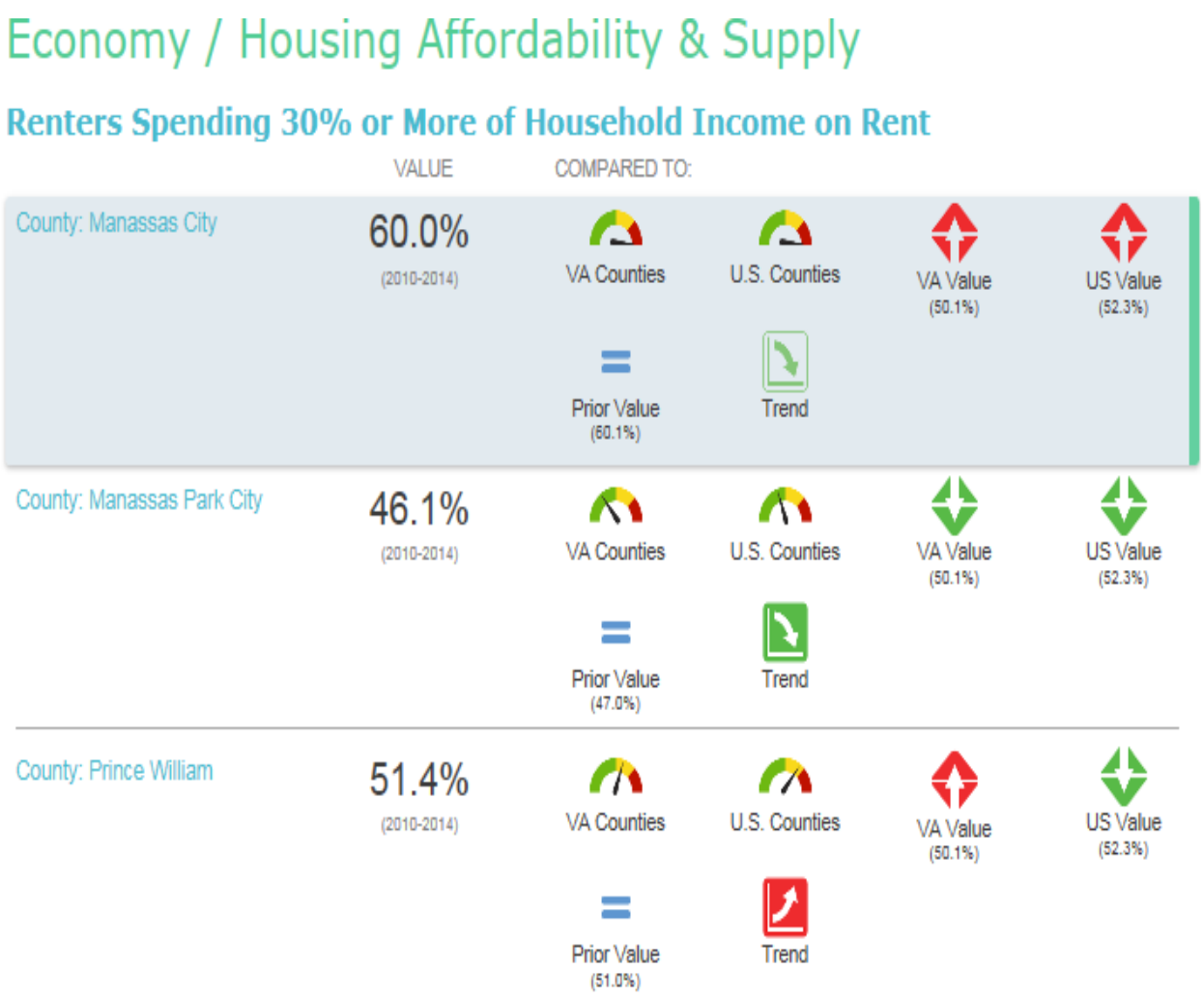
Subject	Manassas Park city, Virginia					
	Total		Below poverty level		Percent below poverty level	
	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Population for whom poverty status is determined	14,941	+/-50	1,396	+/-510	9.3%	+/-3.4
AGE						
Under 18 years	3,878	+/-51	474	+/-258	12.2%	+/-6.6
Related children under 18 years	3,862	+/-55	458	+/-258	11.9%	+/-6.6
18 to 64 years	10,084	+/-109	830	+/-297	8.2%	+/-3.0
65 years and over	979	+/-109	92	+/-79	9.4%	+/-7.9
SEX						
Male	7,539	+/-182	630	+/-259	8.4%	+/-3.4
Female	7,402	+/-172	766	+/-307	10.3%	+/-4.2
RACE AND HISPANIC OR LATINO ORIGIN						
One race	13,794	+/-354	1,207	+/-464	8.8%	+/-3.3
White	10,177	+/-334	671	+/-304	6.6%	+/-3.0
Black or African American	1,933	+/-179	342	+/-202	17.7%	+/-10.2
American Indian and Alaska Native	45	+/-50	0	+/-19	0.0%	+/-44.2
Asian	1,187	+/-248	14	+/-21	1.2%	+/-1.7
Native Hawaiian and Other Pacific Islander	0	+/-19	0	+/-19	-	**
Some other race	452	+/-326	180	+/-228	39.8%	+/-29.7
Two or more races	1,147	+/-344	189	+/-140	16.5%	+/-12.2
Hispanic or Latino origin (of any race)	5,104	+/-4	524	+/-338	10.3%	+/-6.6
White alone, not Hispanic or Latino	5,996	+/-51	412	+/-197	6.9%	+/-3.3

Source: U.S. Census Bureau. (2010). Profile of General Population and Housing Characteristics
Source: 2010-2014 American Community Survey 5-Year Estimates

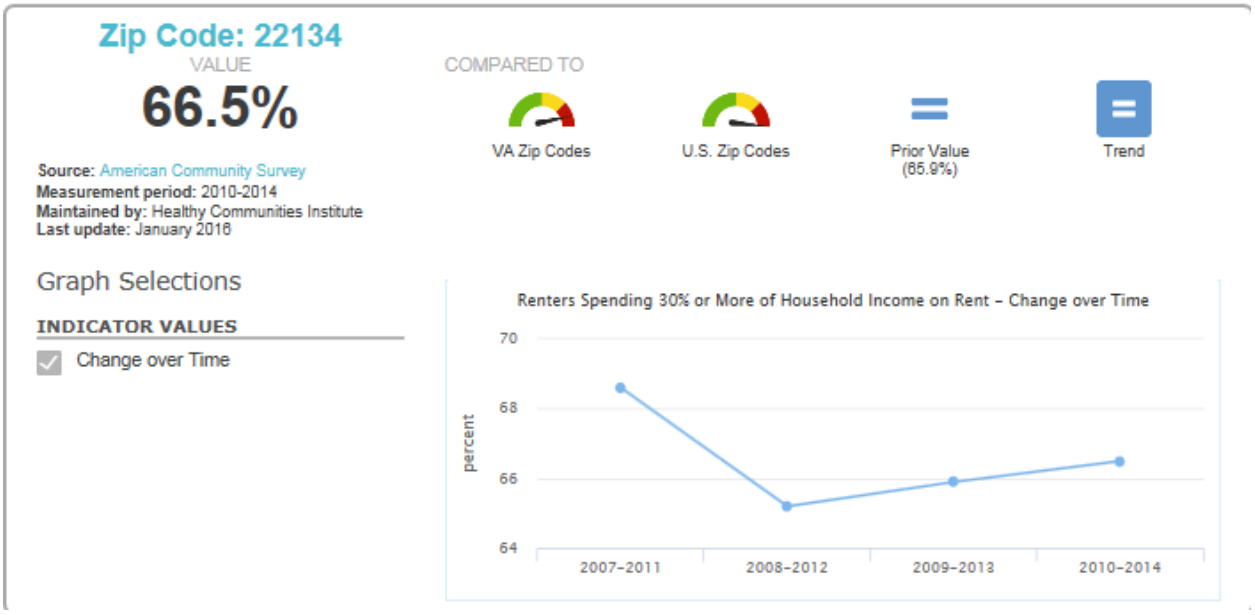
Housing Affordability

Difficulty affording housing is widely acknowledged as a problem in the GPWA, and it appears to becoming more of a challenge particularly for low income renters. Affordability of housing can be measured in several ways, and one of the more common measures is looking at the percentage of households in which the cost for renting is more than 30% of the household income. Quality and affordable housing impacts the health and well-being of our residents. Where one lives, works and plays all contributes to the health and well-being of our community. Spending a high percentage of household income on rent can create financial hardship, especially for lower-income renters. With a limited income, paying a high rent may not leave enough money for other expenses, such as food, transportation and medical. Moreover, high rent reduces the proportion of income a household can allocate to savings each month. Behealthybehappyprincewilliam.com

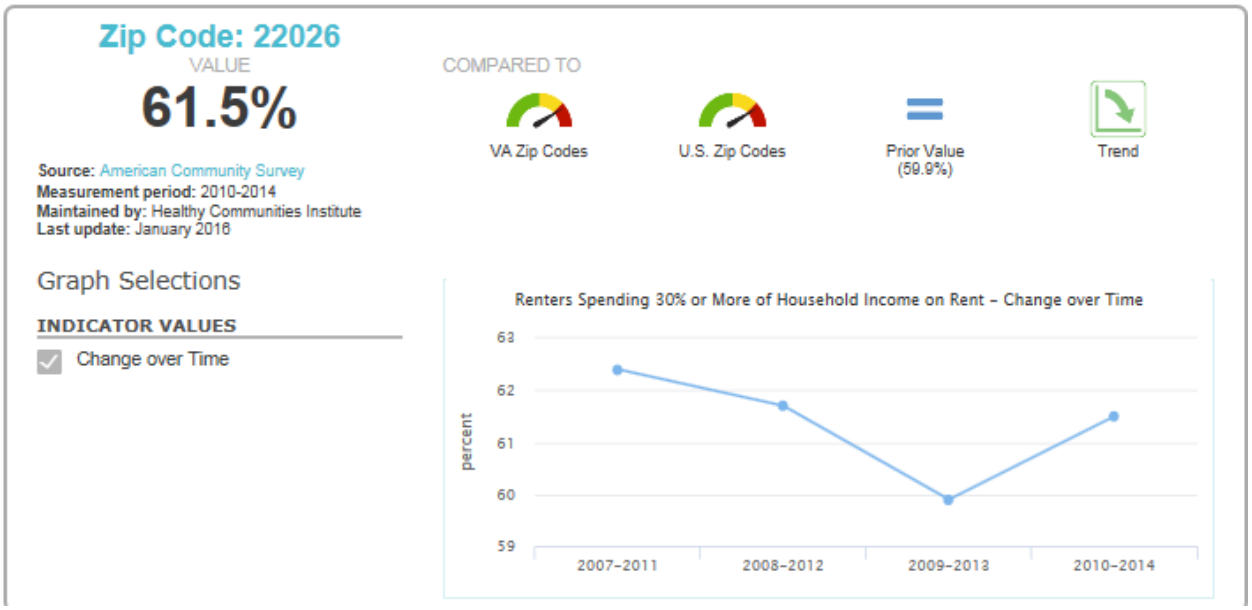
When looking at the Housing Affordability on a total community level, it would appear as if the GPWA does not have a housing affordability issue. Looking more granularly at the Zip code level, shows this is not true, and helps to guide community efforts to those areas most in need. To look at census tract data which demonstrates specifically those communities most impacted by Housing affordability, visit BeHealthyBeHappyPrinceWilliam.com



Quantico



Dumfries



Education

Prince William County

3rd Grade Students Proficient in Reading	77.7% (2014-2015)	VA Counties	VA Value (75.4%)	Prior Value (73.0%)	
8th Grade Students Proficient in Math	81.9% (2014-2015)	VA Counties	VA Value (80.0%)	Prior Value (76.7%)	
8th Grade Students Proficient in Reading	78.3% (2014-2015)	VA Counties	VA Value (75.2%)	Prior Value (74.8%)	
High School Graduation	91.4% (2015)	VA Counties HP 2020 Target (82.4%)	VA Value (90.5%)	US Value (82.3% in 2014)	Prior Value (90.6%)
People 25+ with a Bachelor's Degree or Higher	38.1% (2010-2014)	VA Counties Prior Value (38.1%)	U.S. Counties	VA Value (35.8%)	US Value (29.3%)
People 25+ with a High School Degree or Higher	89.6% (2010-2014)	VA Counties	U.S. Counties	VA Value (87.9%)	US Value (86.3%)

Manassas City

3rd Grade Students Proficient in Math	72.1% (2014-2015)	VA Counties	VA Value (74.5%)	Prior Value (58.2%)	
3rd Grade Students Proficient in Reading	71.1% (2014-2015)	VA Counties	VA Value (75.4%)	Prior Value (65.3%)	
8th Grade Students Proficient in Math	73.9% (2014-2015)	VA Counties	VA Value (80.0%)	Prior Value (63.9%)	
8th Grade Students Proficient in Reading	66.6% (2014-2015)	VA Counties	VA Value (75.2%)	Prior Value (53.2%)	
High School Graduation	85.9% (2015)	VA Counties	VA Value (90.5%)	US Value (82.3% in 2014)	Prior Value (86.1%)

	VALUE	COMPARED TO:			
People 25+ with a Bachelor's Degree or Higher	29.1% (2010-2014)	VA Counties	U.S. Counties	VA Value (35.8%)	US Value (29.3%)
		Prior Value (28.7%)			
People 25+ with a High School Degree or Higher	82.7% (2010-2014)	VA Counties	U.S. Counties	VA Value (87.9%)	US Value (86.3%)

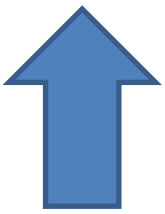
Manassas Park City

	VALUE	COMPARED TO:			
3rd Grade Students Proficient in Math	72.1% (2014-2015)	VA Counties	VA Value (74.5%)	Prior Value (58.2%)	
3rd Grade Students Proficient in Reading	71.1% (2014-2015)	VA Counties	VA Value (75.4%)	Prior Value (65.3%)	
8th Grade Students Proficient in Math	73.9% (2014-2015)	VA Counties	VA Value (80.0%)	Prior Value (63.9%)	
8th Grade Students Proficient in Reading	66.6% (2014-2015)	VA Counties	VA Value (75.2%)	Prior Value (53.2%)	
High School Graduation	85.9% (2015)	VA Counties	VA Value (90.5%)	US Value (82.3% in 2014)	Prior Value (86.1%)

	VALUE	COMPARED TO:			
People 25+ with a Bachelor's Degree or Higher	29.1% (2010-2014)	VA Counties	U.S. Counties	VA Value (35.8%)	US Value (29.3%)
		Prior Value (28.7%)			
People 25+ with a High School Degree or Higher	82.7% (2010-2014)	VA Counties	U.S. Counties	VA Value (87.9%)	US Value (86.3%)
		Prior Value (82.6%)			

Violent Crime Rate

GPWA Violent Crime (2010-2012)

PWC	MC	MPC	VA
148.4 	350.5 	115.3 	200.2

2014 Closure Rates

Violent Crimes	Actual	Cleared	Closure Rate
Murder	6	7*	116.7%
Rape	58	61*	105.2%
Aggravated Assault	257	222	86.4%
Robbery	194	77	39.7%
TOTAL VIOLENT CRIMES	**515**	**367**	71.3%
Property Crimes	**Actual**	**Cleared**	**Closure Rate**
Burglary	601	145	24.1%
Larceny	4,729	1,107	23.4%
Motor Vehicle Theft	274	64	23.4%
TOTAL PROPERTY CRIMES	**5,604**	**1,316**	**23.5%**

**Five of the six murders that occurred in 2014 have been cleared. One murder investigation remains active. In addition, two murders and nine rapes from previous years were cleared in 2014.*

Prince William County 2014 Crime Report

VIOLENT CRIMES

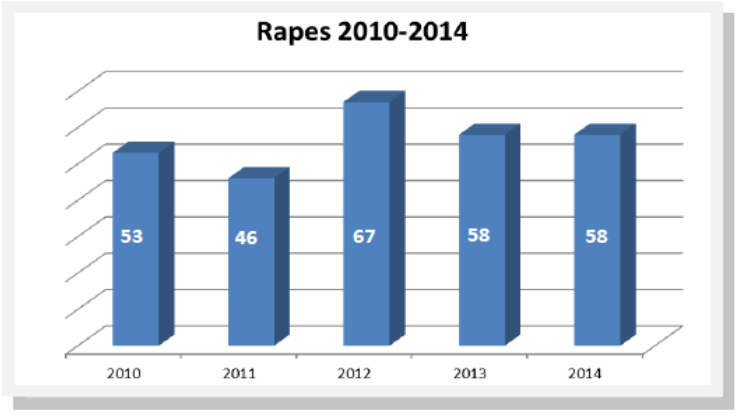
Historical Perspective

RAPE

⇒ Same as 2013.

⇒ 28 (48.3%) of the reported victims were juveniles.

⇒ Two stranger rapes occurred and arrests have been made in both cases.



AGGRAVATED ASSAULT

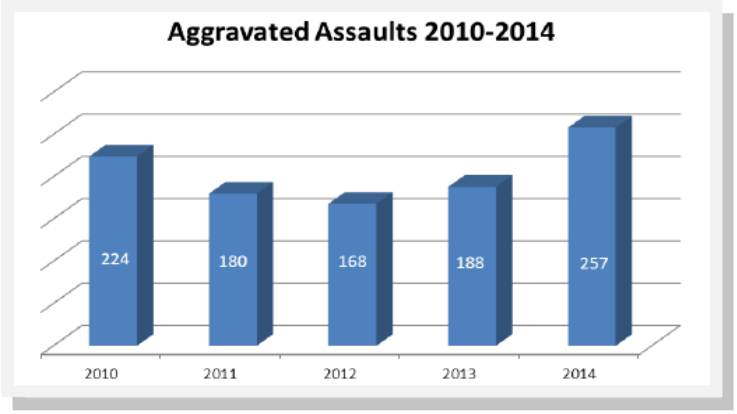
⇒ 257 aggravated assaults reported, resulting in a 36.7% increase.

⇒ Use or display of a firearm: 8.1%

⇒ Use of a knife or cutting instrument: 27.1%

⇒ Use of another type of dangerous weapon: 23.3 %

⇒ Use of a personal weapon (hands, feet, etc): 41.5%



Community Healthcare Coalition of Greater Prince William

The purpose of the CHCGPW is to bring together a multiagency and multidisciplinary group of entities and individuals to develop a sustainable dashboard of community health indicators (CHI) that represents the work of the coalition, and to use existing recognized platforms to identify and prioritize community health issues, conduct a community health assessment, and plan, implement and evaluate a community health improvement process. The Coalition will also be responsible for identifying ways limited, applicable resources can be used most efficiently and effectively.

I. Vision and Mission

Vision: Greater Prince William Area is a community of healthy people.

Mission: The Community Healthcare Coalition of Greater Prince William will work collectively to improve the health of our community by utilizing limited resources most efficiently and effectively.

II. Goal

The goal of the CHCGPW is to collectively improve the health of the residents of the Greater Prince William Area and jurisdictions served by the participating entities.

The goal of the Coalition to improve the health of the community will be accomplished by:

- Use of a shared dashboard as a robust source of secondary data
- Collection of comprehensive primary data to support interpretation of secondary data and enhance the quality of community health assessments
- Prioritization of community health needs
- Coordination of comprehensive implementation strategies to maximize impact on specific health needs and priority communities
- Evaluation of implemented strategies and institution of quality improvement initiatives as needed
- Mobilization of expertise, resources, effective skills-based health education, and accountability for community health outcomes

- Establishment of stronger relationships and partnerships between the hospitals, community health center, Health District, George Mason University, and other members of the healthcare community

- Promotion of a safe, healthy environment, both physical and psychosocial and activities that improve access to health services

Essential Membership:

- George Mason University
- Greater Prince William Community Health Center
- Novant Health UVA Health System(Prince William Medical Center & Haymarket Medical Center)
- Potomac Health Foundation
- Prince William Health District
- Sentara Northern Virginia Medical Center

Essential Members

George Mason University is a public institution and the largest research university in Virginia. George Mason is based in Fairfax County. Additional campuses are located nearby in Arlington County, Prince William County and Loudoun County. The university enrolls approximately 34,000 students, making it the largest university by head count in the Commonwealth of Virginia and is recognized for its strong programs in economics, law, creative writing, computer science and business. For additional information, please visit: https://www.gmu.edu/.

The ***Greater Prince William Community Health Center*** provides primary, prenatal, dental and behavioral health care to all residents of Prince William County and the Cities of Manassas and Manassas Park regardless of age, income or insurance status. For additional information, please visit: http://gpwhealthcenter.org/.

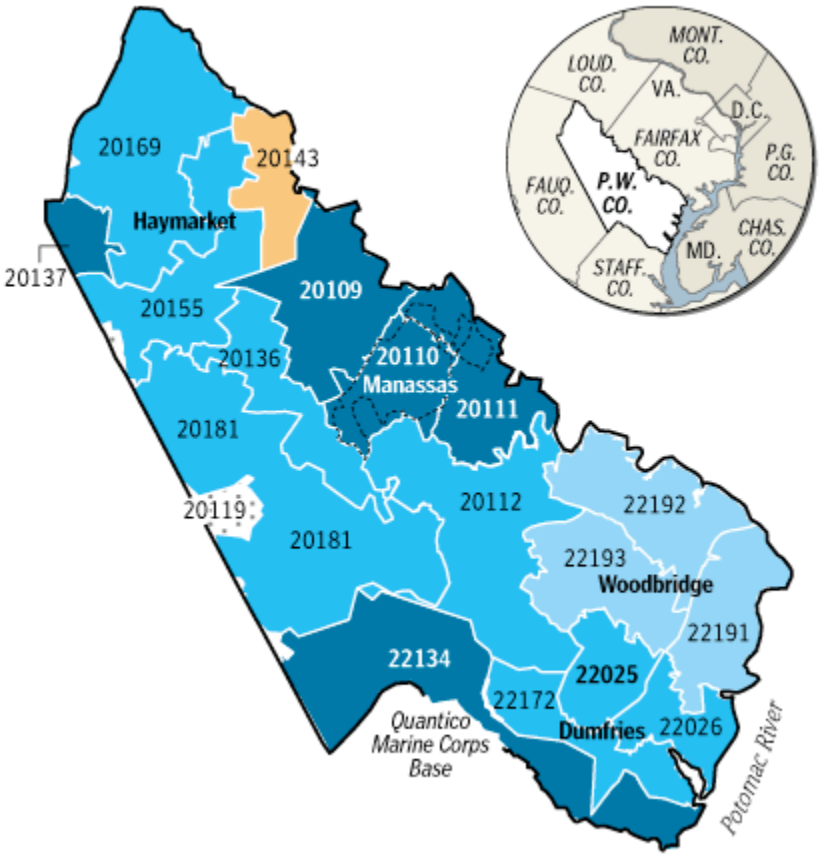
Novant Health UVA Health System provides emergency services, maternity care, surgery, pediatrics, cancer care, heart and vascular, and behavioral health services. The Medical Center also features comprehensive outpatient services in Gainesville, Haymarket, South Riding and Woodbridge. These locations include Novant Health physician practices, imaging, The Cancer Center at Lake Manassas, lab and rehabilitation. The campus in Manassas, Virginia is home to 170-beds. Located a short distance from the hospital is Caton Merchant House, Novant's assisted-living facility. For additional information, please visit: https://www.novanthealth.org/prince-william-medical-center.aspx. In early 2014, Novant opened Novant Health Haymarket Medical Center. Novant Health Haymarket Medical Center located in Haymarket, Virginia is a 60-bed, acute care hospital that also features physician offices and the Haymarket Ambulatory Surgery Center. For additional information, please visit: https://www.novanthealth.org/haymarket-medical-center.aspx.

Potomac Health Foundation is a private, independent health foundation located in Woodbridge, Virginia. It was established in December 2009 as a result of the merger between Potomac Community Hospital and Sentara Healthcare. Potomac Health Foundation serves the communities in eastern Prince William County, Virginia and adjacent communities in southeast Fairfax and north Stafford Counties. Potomac Health Foundation is a grant making organization that focuses on promoting wellness and preventing disease. It does not provide health services directly to consumers, but it does offer financial support to tax-deductible organizations that do. Potomac Health Foundation is governed by an all-volunteer Board of Directors comprised of civic leaders and health specialists from the region. They are dedicated and caring members of the community who wish to promote healthy outcomes for all persons and healthy communities throughout our area. For additional information, please visit: http://potomachealthfoundation.org/

The ***Prince William Health District (PWHD)*** operates multiple programs to protect and improve the health and well-being of its residents. Services provided include: immunizations; high risk and routine maternity care; environmental health services, including restaurant and pool inspections; family planning services; confidential diagnosis, treatment, and counseling for sexually transmitted diseases; tuberculin testing and diagnostic chest x-rays; confidential HIV testing and early intervention services; nutritional education and food vouchers for women, infants, and children (WIC) clients; processing of birth and death certificates, and investigation of reportable diseases. Services are provided at several different locations throughout Prince William County.

Sentara Northern Virginia Medical Center is a 183-bed hospital located in Woodbridge, Virginia. Sentara provides comprehensive, quality clinical services, including advanced imaging, lab services, cardiovascular, emergency care, vascular and weight loss. Sentara primarily serves residents of Prince William County, but also Fairfax County (Lorton and Springfield), Stafford and Alexandria. For additional information, please visit: http://www.sentara.com/Northern-Virginia/Pages/Home.aspx.

Health Opportunity Index and Social Determinants of Health



The Virginia Health Opportunity Index (HOI) was first developed in 2012 as part of the Virginia Health Equity Report. This index provides a way to measure the social determinants of health – the social, economic, educational, demographic and environmental factors that relate to a community's well-being. It is part of the state's continuing efforts to become the healthiest state in the nation.

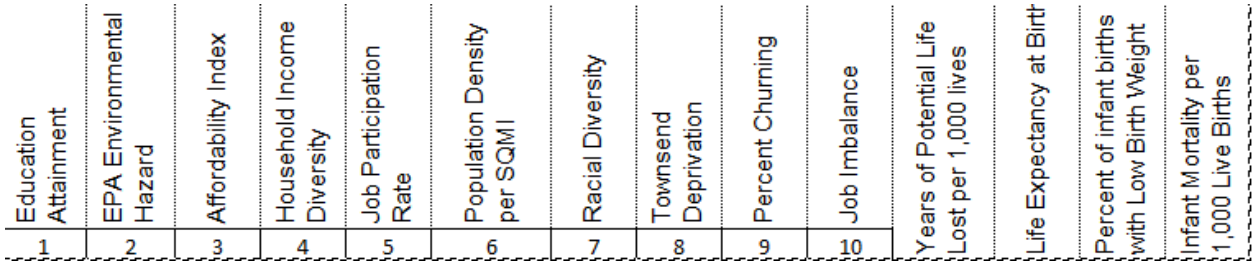
The Virginia HOI consists of 13 indicators help to calculate the HOI. These indicators were chosen by VDH after an extensive review of the literature on the Social Determinants of Health (SDOH). Although there are many variables and indicators that could be included, indicators were chosen based on the following criteria:

- Their influence on health as expressed in the literature
- Input from Local Health Districts and other stakeholders

- The availability of data of consistent quality at the Census Tract level for all tracts in Virginia

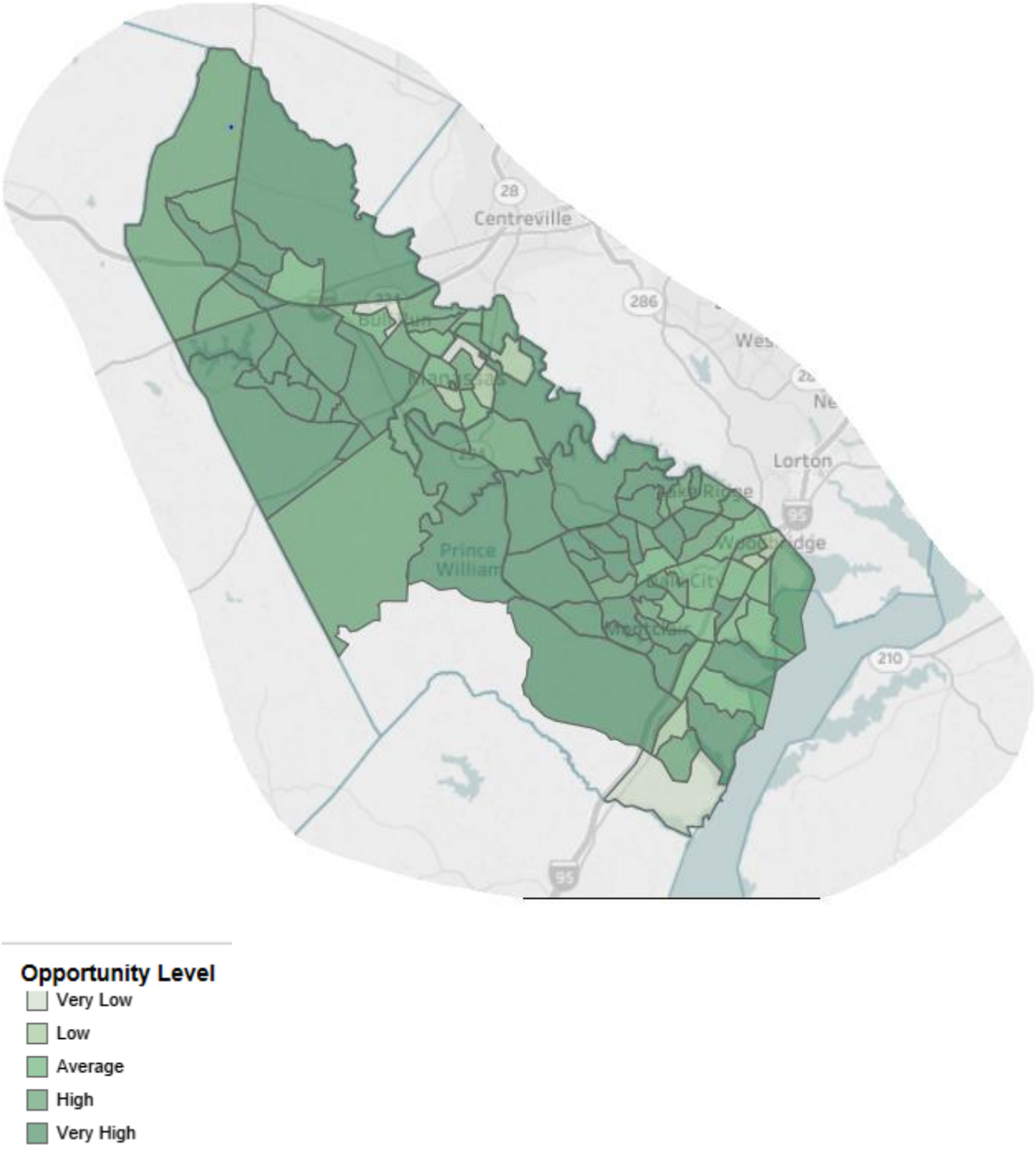
Those 13 indicators are organized into four profiles:

- Community Environmental (indicator of natural, built and social environment)
- Consumer Opportunity (measure of consumer resources available)
- Economic Opportunity (measure of economic opportunities available, highlighting employment and income)
- Wellness Disparity (measure of disparate access to health services)



The data gathered was combined into a single index of information. The data shows that counties with the lowest rankings in community environment also tend to rank low in overall health opportunity. This data demonstrates where a person lives, works and plays also impacts health.

Health Opportunity Index Prince William Health District



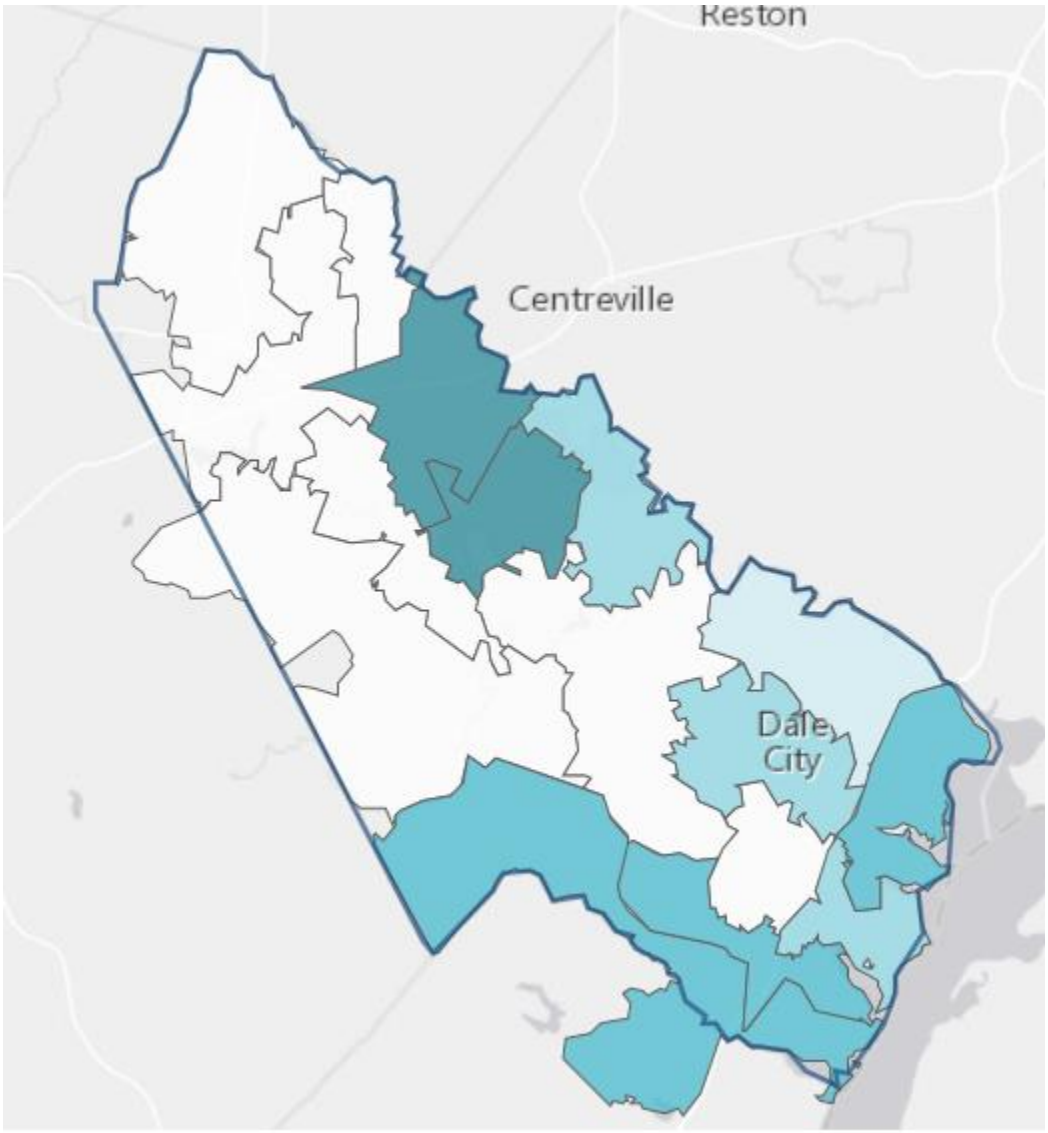
Opportunity Level

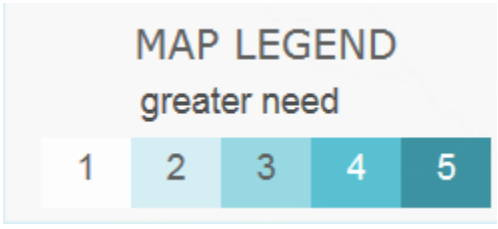
- Very Low
- Low
- Average
- High
- Very High

https://www.vdh.virginia.gov/omhhe/hoi/dashboards/counties

Social Determinants of Health

The **2016 SocioNeeds Index**, created by Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes.





http://www.behealthybehappyprincewilliam.com/index.php?module=Indicators&controller=index&action=socioneeds

This demonstrates how two communities can be adjacent to one another and have very different health outcomes. This index helps to target efforts on the areas of most need. Health is impacted by our social and physical environment as well as access to care, lifestyles, and behaviors. Health is also affected by our social and economic opportunities. Healthy people 2020 addresses social determinants by encouraging communities to create environments that support good health and a better quality of life. The Virginia Plan for Well-being emphasizes good health for all Virginians, and that all Virginians have the opportunity for good health. According to Healthy People 2020, there are five main areas that impact health:

Economic Stability
Education
Social and Community Context
Health and Health Care
Neighborhood and Built Environment

1Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States. July 26, 2010. Available from: http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm

In order to address these inequities that impact health and the quality of life of our residents, health considerations need to be incorporated into community planning and policies that requires the public health system to work together. Better mental and physical health is dependent upon where we live, work and play.

Countyhealthrankings.org

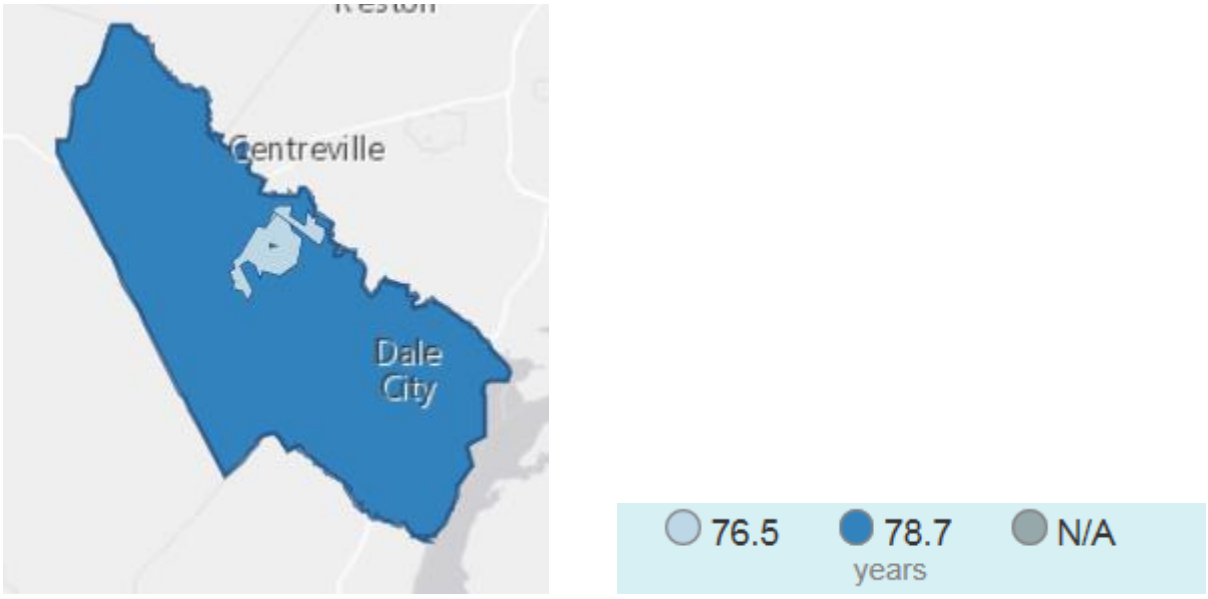
Life Expectancy

Life expectancy is defined as the average number of years of life remaining at a given age. The life expectancies calculated below reflect years remaining of life from birth. Where we live is a good predictor of health. The social, economic, and physical environments in which we live impact our wellbeing. Where we live has a significant impact on financial security, school quality, job opportunities, safety, as well as access to goods and services.

Among other things, communities with lower income and educational levels tend to have higher rates of asthma, obesity, diabetes, heart disease, and child poverty. These same communities are also more likely to have substandard housing, underfunded schools, poor access to grocery stores and supermarkets, and to be located near highways and other sources of pollution.

Unnatural Causes
(http://www.unnaturalcauses.org/resources.php?topic_id=6

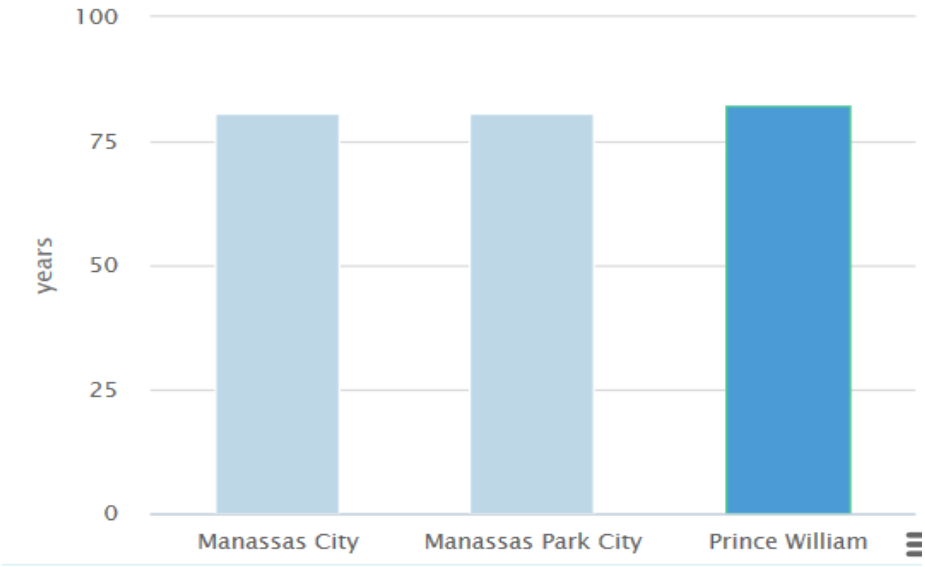
The Greater Prince William Area has seen an increase in life expectancy in both female and male residents, although, not all communities have benefited as well as other communities.

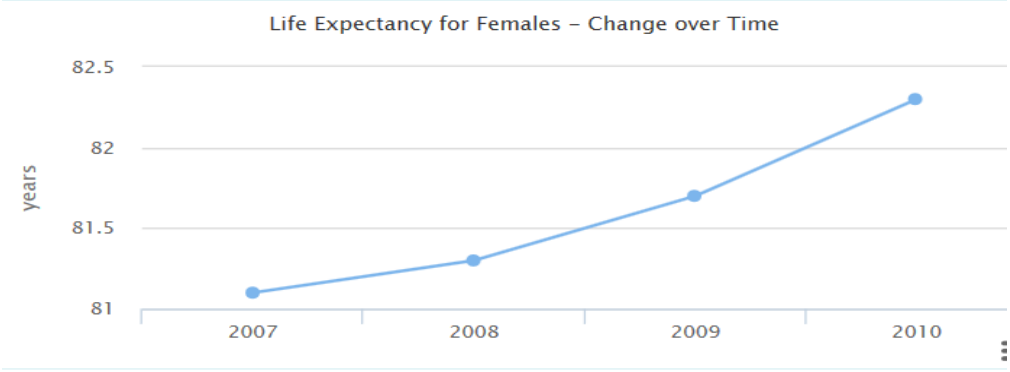


Life Expectancy in the Greater Prince William Area

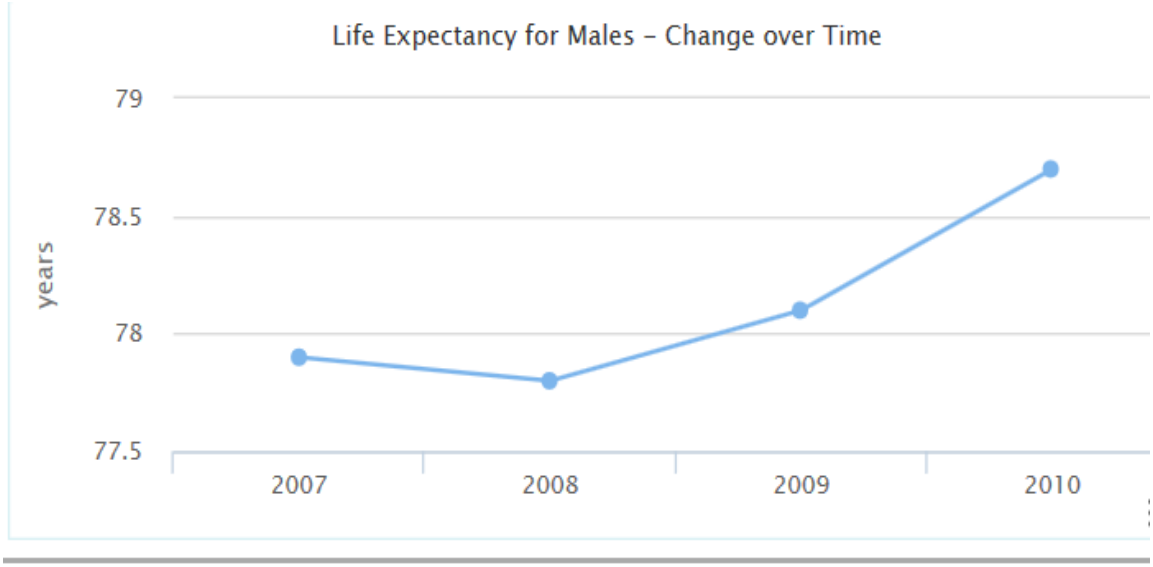
	Female	Male
PWC	82.3	78.7
Manassas City	80.8	76.5
Manassas Park City	80.8	76.5
VA	80.7	76.3
US	80.8	76.1

Female Life Expectancy





Male Life Expectancy



Death Rates

Leading Causes of Death

- Prince William County death rates are lower than Virginia for all causes except for Influenza and Pneumonia deaths.
- Manassas City's Death rate for cerebrovascular disease, chronic lower respiratory diseases, nephritis and nephrosis, and primary hypertension and renal disease are greater than Virginia death rates for these conditions. The most significant at twice the rate is primary hypertension and renal disease death rate.
- Manassas Park's death rates for Diabetes, nephritis and nephrosis, and suicide is greater than Virginia death rates for these conditions. The most significant is the Diabetes death rate which is twice that of the state death rate.
- The Diabetes death rate in Manassas Park was one quarter of the state rate the year before (2012).
- There were no suicides in Manassas Park the year before.
- Manassas City's death rates for the various conditions had not changed from the year before except nephritis and nephrosis death rate was not greater than the state.
- Prince William County leading causes of death in 2012 included Primary hypertension and renal disease and septicemia.
- All three jurisdictions meet the Healthy People 2020 goal for reducing cancer mortality to below 161.4 deaths per 100,000.
- Although the Diabetes Death Rate was above the state in Manassas Park City it was below the Health People 2020 goal of 66.6 deaths per 100,000.

Indicator (2013 Death Rate per 100,000 population)	PWC	MC	MP	VA
Total Death Rates	608.0	713.4	457.6	720.1
Malignant Neoplasms	135.7	154.6	71.2	161.3
Diseases of the Heart	126.8	145.1	97.9	155.9
Cerebrovascular	27.2	52.2	25.0	38.5
Chronic lower Respiratory Disease	32.3	56.7	30.3	37.2
Unintentional Injury	26.1	53.2	0.0	33.0
Alzheimer's Disease	12.9	12.6	14.5	19.6
Diabetes Mellitus	16.4	16.9	37.1	18.3
Nephritis and Nephrosis	9.6	7.2	24.0	18.0
Septicemia	11.4	8.1	0.0	17.7
Influenza and Pneumonia	20.2	8.4	6.0	16.8
Suicide	9.8	9.1	16.9	12.2
Chronic Liver Disease	5.1	6.6	0.0	8.9
Primary Hypertension and Renal Disease	6.8	12.0	0.0	7.6

Source: Virginia Vital Statistics 3012 and 2013, Healthy People 2020 Goal C-1 Cancer death rate 166.4 deaths per 100,000 population and Goal D-3 diabetes death rate 66.6 deaths per 100,000 population. ND = no data.

Cancer

The Virginia Cancer Report for 2013, Cancer in Virginia, documents the burden of cancer incidence and mortality in Virginia. The report covers the years 2001 – 2010 (for incidence statistics) and 2001 – 2011 (for many mortality statistics) for all cancers combined and for cancers of the cervix, colon, female breast, lung, melanoma of the skin, and ovary.

The report presents information on cancers that are at the top of the list of common cancers. These cancers were selected because many among them occur often or are targets of efforts to screen and control or prevent them. **Female breast cancer** and **prostate cancer** are the two most commonly diagnosed cancers among their respective sexes. **Cervical cancer** provides an example of successful prevention and control policies; screening can detect it and vaccination can prevent the majority of cases. **Lung cancer** and **colorectal cancer** are the most common cancers affecting every segment of the population. However, large differences exist between White and African-American rates and between male and female rates. The differences highlight targets for prevention and control activities. **Melanoma** is included as an example of a cancer that often people can prevent through simple steps to reduce risk. Practicing sun safety and being cautious about other sources of ultra-violet (UV) light, such as tanning beds, are behaviors that reduce risk. **Ovarian cancer** is more often diagnosed at a later stage than other cancers in this group. The reason is that ovarian cancer may develop without symptoms apparent to the patient until the disease is advanced. An ovarian cancer screening test currently does not exist; this fact also influences the likelihood of diagnosis at a later stage.

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in 5 years, yet cancer remains a leading cause of death in the United States, second only to heart disease. The cancer objectives for Healthy People 2020 support monitoring trends in cancer incidence, mortality, and survival to better assess the progress made toward decreasing the burden of cancer in the United States. The objectives reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests identified in the U.S. Preventive Services Task Force (USPSTF) recommendations. The objectives for 2020 also highlight the importance of monitoring the incidence of invasive cancer (cervical and colorectal) and late-stage breast cancer, which are intermediate markers of cancer screening success.

In an era of patient-centered care, effective communication between clinicians and their patients and family members fosters shared knowledge and understanding and leads to medical decisions that align with patient values. The objectives assess whether people understand and remember the information they receive about cancer screening. Research

shows that a recommendation from a health care provider is the most important reason patients cite for having cancer screening tests.

Why Is Cancer Important?

Many cancers are preventable by reducing risk factors such as:

Use of tobacco products
Physical inactivity and poor nutrition
Obesity
Ultraviolet light exposure

Other cancers can be prevented by getting vaccinated against human papillomavirus (HPV) and hepatitis B virus.

Screening is effective in identifying some types of cancers in early, often highly treatable stages (see USPSTF recommendations), including:

Breast cancer (using mammography)
Cervical cancer (using Pap test alone or combined Pap test and HPV test)
Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

Cancer Data by Health District – All Sites, incidence (2006-2010) & mortality (2007-2011)
Districts are ranked from favorable (1) to unfavorable (35) for incidence, local stage, and mortality.

Health District	Incidence Count	Incidence Rate per 100,000	State Ranking	Percent Local Staging	State Ranking	Mortality Count	Mortality Rate per 100,000	State Ranking
Prince William	6,445	415.9	6	47.6	13	2,229	162.9	5

Cancer in Virginia, 2013, VDH

The Greater Prince William Area ranked in the top ten out of 35 health districts in cancer incidence and mortality, but not for local staging, which may mean that the community needs to address community cancer screening education and access to care.

Breast cancer (female)

- Breast cancer is one of the most diagnosed cancers in women after lung cancer. It is a leading cause of cancer mortality.
- Mammography screening rates were noted to be lower for women with less education, lower income, and uninsured. Cancer in Virginia 2013
- According to community providers and breast cancer prevention advocates, women with Medicare were less likely to be screened because primary care providers were less likely to address and recommend screening due to a patient's multiple other health issues.

Colorectal Cancer

- Colorectal cancer is the third most commonly diagnosed cancer in the United States, although the incidence and mortality rate due to colorectal cancer has decreased.
- According to the 2012 BRFSS, 69.0 percent of Virginia adults aged 50 years old and older reported ever having an endoscopy. Colorectal screening was greater among African Americans at 68 percent versus whites at 64.7 percent.
- Colorectal screening rates were lower among adults who were less educated, and did not have insurance. VDH, Cancer in Virginia 2013

Lung Cancer

- Lung cancer is the second most commonly diagnosed cancer and a leading cause of death for both men and women in the United States.
- According to 2012 BRFSS survey data, 19.0 percent of adults in Virginia were current smokers (U.S. average, 17.0%). VDH, Cancer in Virginia 2013
- Prevalence of current smoking was higher among those who were less educated (31.5% for less than high school versus 8.0% for college graduate) lower income (32.2% for $15,000 or less versus 13.3% for $50,000 and above), and uninsured (36.5% for uninsured versus 15.9% for insured).

Prostate Cancer

- Among men, prostate cancer is the most commonly diagnosed cancer (excluding non-melanoma skin cancer) and the second leading cause of cancer death in the United States. One in seven men will be diagnosed with prostate cancer during their lifetime.
- Although the value of PSA screening is under debate, according to the 2012 BRFSS survey data, 46.5 percent of Virginia men 50 years and older reported having had a Prostate-Specific Antigen (PSA) screening test in the previous two years (U.S. average, 45.2%).
- Also from the 2012 BRFSS survey data, 18.2 percent of men over age 40 with an annual income of $15,000 or less had a PSA screening in 2012. VDH, Cancer in Virginia 2013
- Manassas City appears to have a higher cancer mortality rate for cancers that have screening methods. Additionally, Manassas City has the lowest median income of the three localities. Concerning because all but colorectal has a lower incidence than VA.
- Generally, GPWA has a lower incidence of cancer than the state.

GPWA Cancer Mortality Rates per 100,000 (2009-2013)

Cancer Type	PWC	MC	MPC	VA	HP 2020 Goal
Female Breast	20.6	24.5	No Data	22.2	20.7
Colorectal	12.3	17.8	No Data	14.5	14.5
Lung	40.9	38.8	42.0	47.0	45.5
Prostate	21.5	43.4	No Data	22.2	20.8

GPWA Cancer Incidence Rate per 100,000 (2009-2013)

Cancer Type	PWC	MC	MPC	VA
Female Breast	111.8	11.5	74.3	125.5
% Medicare Patient (2014)	7.5	6.1	No Data	8.1
Colorectal	32.4	39.1	44.5	37.5
Lung	48.4	55.1	41.4	62.1
Prostate	89.7	99.4	85.6	116.5

ND= no data

Percent Mammogram Screening (Medicare 2014)

PWC	MC	MPC	VA
56.0%	54.2	52.0	63.0

VA Cancer Report 2013

Percent if Adults over 18 yo with Insurance

PWC	MC	MPC	VA	HP 2020 Goal
84.9	76.0	75.4	85.2	100.0

Maternal Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The objectives of the Maternal, Infant, and Child Health topic area address a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life of women, children, and families.

Why Are Maternal, Infant, and Child Health Important?

Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children. These health risks may include:

Hypertension and heart disease
Diabetes
Depression
Genetic conditions
Sexually transmitted diseases (STDs)
Tobacco use and alcohol abuse
Inadequate nutrition
Unhealthy weight

The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Healthy People 2020 Maternal, Infant and Child Health

Low birth weight (LBW) is defined as less than 2500 grams (5 pounds 8 oz.) regardless of the gestational age. Normal weight is 2500-4000 grams. Low birth weight can be caused by preterm birth (less than 37 weeks gestation) or small for gestational age. LBW babies are at greater risk of fetal or infant demise.

The infant mortality rate (IMR) is an estimate of the number of infant deaths for every 1,000 live births. This rate is often used as an indicator to measure the health and well-being of a nation, because factors affecting the health of entire populations can also impact the mortality rate of infants. www.cdc.gov

Early and adequate prenatal care (PNC) helps to promote healthy pregnancies through screening and management of a woman's risk factors and health conditions, as well as education and counseling on healthy behaviors during and after pregnancy.

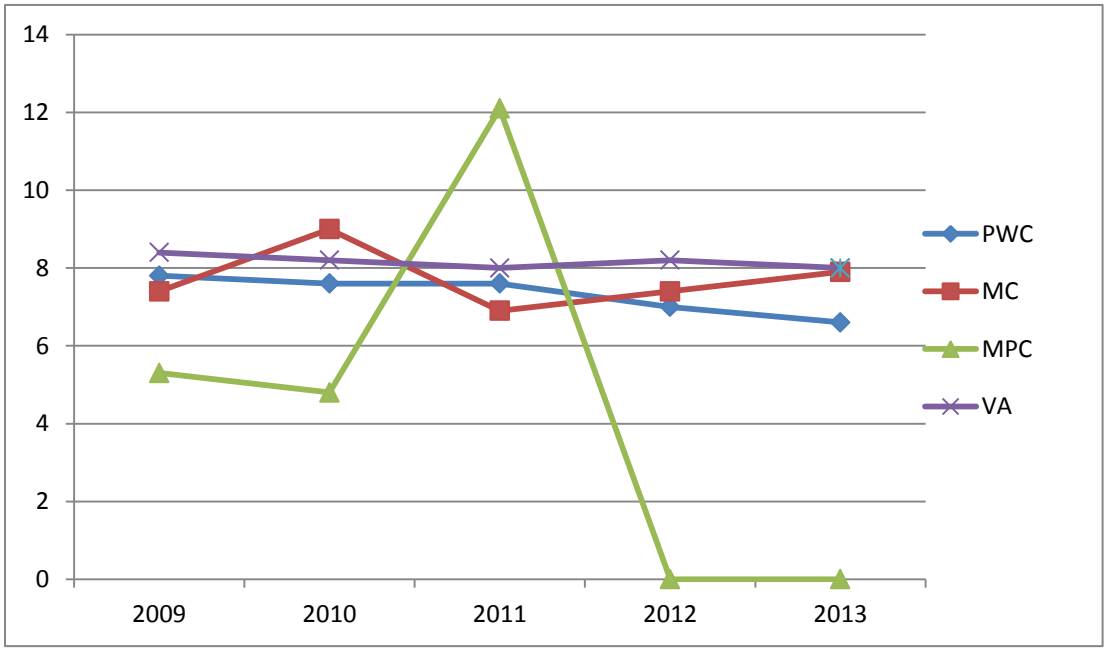
The rates of the first trimester prenatal care increased with greater education attainment, from only 58.0 percent of mothers with less than a high school diploma to 86.3 percent of mothers with a bachelor's degree or higher. First trimester prenatal care initiation was highest among non-Hispanic White and non-Hispanic Asian women (78.8 and 77.8 percent, respectively), followed by Hispanic (68.3 percent) and non-Hispanic Black women (63.4 percent), while non-Hispanic American Indian/Alaska Native and non-Hispanic Native Hawaiian/Other Pacific Islander women had the lowest rates of early prenatal care (59.0 and 55.7 percent, respectively) MCHB.hrsa.gov

Maternal Child Data 2014

	PWC	MC	MP	VA	HP2020 Goal
LBW	7.5	7.6	0.0	7.9	7.8
IMR	6.0	6.6	0.0	6.2	6.0
Early PNC	80.4	75.9	68.4	82.9	77.9

LBW= low birth weight IMR=Infant Mortality Rate PNC=Prenatal Care

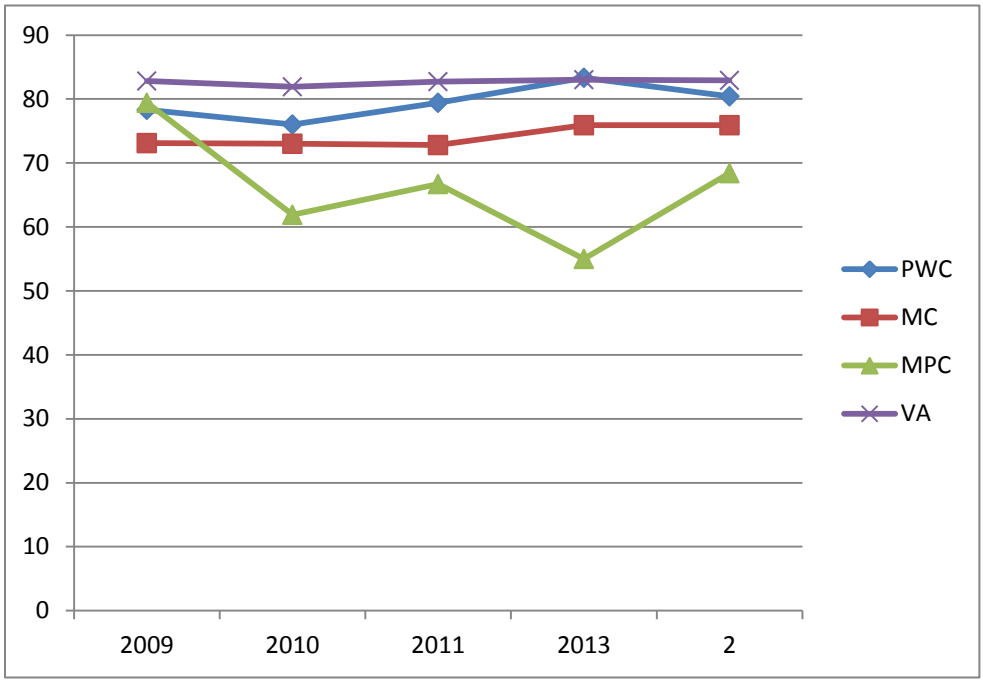
GPWA Low Birth Weight



VDH Health Statistics

HP2020 Goal=7.8

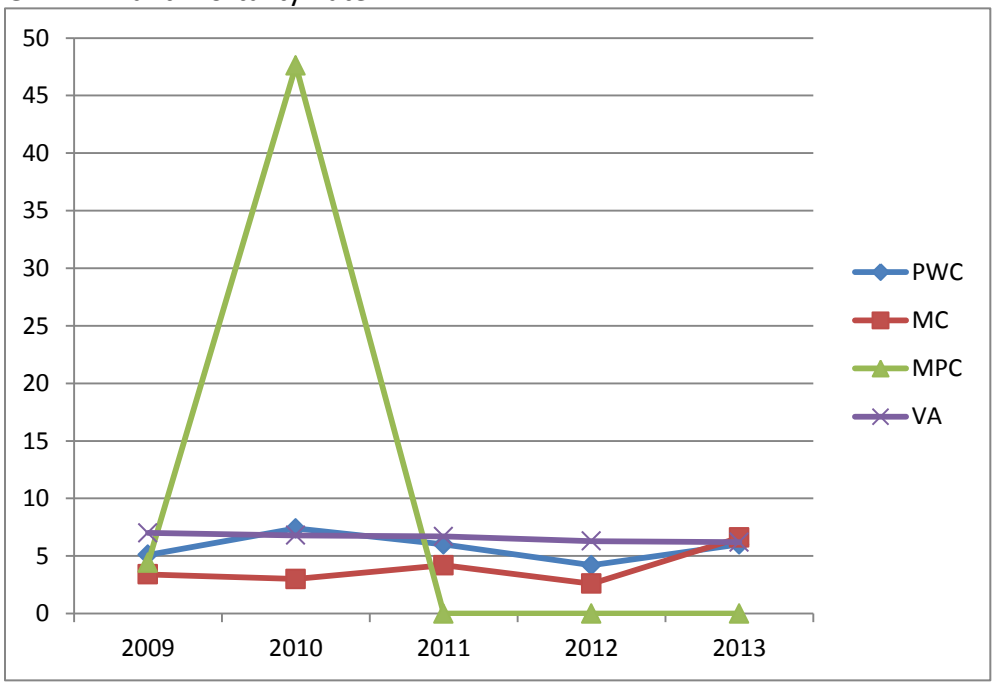
GPWA Percent with Early Prenatal Care



VDH Health Statistics

HP2020 Goal=77.9%

GPWA Infant Mortality Rate



VDH Health Statistics HP2020 Goal=6.0

Highlights

- In 2013, African American women suffered a higher infant mortality rate (IMR) than any other race. In PWC, IMR for White women was 4.5 and Black women 13.7. In Manassas City, the IMR for White women was 5.8, and for Black women 19.0. This has been persistent over the years and is consistent with state and national data.
- In 2014, low birth weight (LBW) deliveries were more common in African American women than any other race. This has been a persistent issue over the years, and is consistent with state and national data.
- GPWA has significantly increased its prenatal care resources over the last few years for Medicaid and uninsured residents. Now there are three Community Health Center sites, and an East end hospital clinic. Additionally UVA Culpeper Hospital offer both High Risk and general Prenatal Care.
- Manassas Park City has the largest number of uninsured residents, which is consistent with a lower number of women receiving early PNC. Due to the increased number of options for the uninsured to receive PNC, the percent of women in Manassas Park City receiving early PNC has risen.

GPWA IMR by Race

	PWC	MC	MPC
Total	6.0	4.5	6.2
White	4.5	5.8	3.2
Black	13.7	19.0	12.0
Other	2.3	No data	2.2

2013 VDH Health Statistics

GPWA LBW by Race

	PWC	MC	MPC	VA
Total	7.5	2.7	7.6	7.9
White	6.3	2.7	7.5	6.4
Black	10.6	No Data	9.2	12.4
Other	7.9	3.2	6.8	7.7

2014 VDH Health Statistics

Mental Health

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery. Healthy People 2020 Mental Health

Indicator	PWC	MC	MPC	VA
Age Adjusted Suicide Death Rate per 100.000 (2013)	9.8	4.1	16.9	12.2
Percent of Medicare with depression	10.6	12.3	No data	14.7
Percent with frequent days with mental stress	8.5	9.4	9.4	6
Mental Health Provides per 100,000 pop.	100	302	14.0	14.6

Table 1.1 Number of OCME Cases by District and Manner of Death, 2014

	OCME District				
Manner	**Central**	**Northern**	**Tidewater**	**Western**	**Total**
Accident	786	673	486	687	**2632**
Homicide	116	50	125	67	**358**
Natural	569	372	375	513	**1829**
Suicide	326	320	234	266	**1146**
Undetermined	15	55	79	55	**204**
TOTAL	**1812**	**1470**	**1299**	**1588**	**6169**

Figure 1.4 Number of OCME Cases by Manner of Death and Race/Ethnicity, 2014

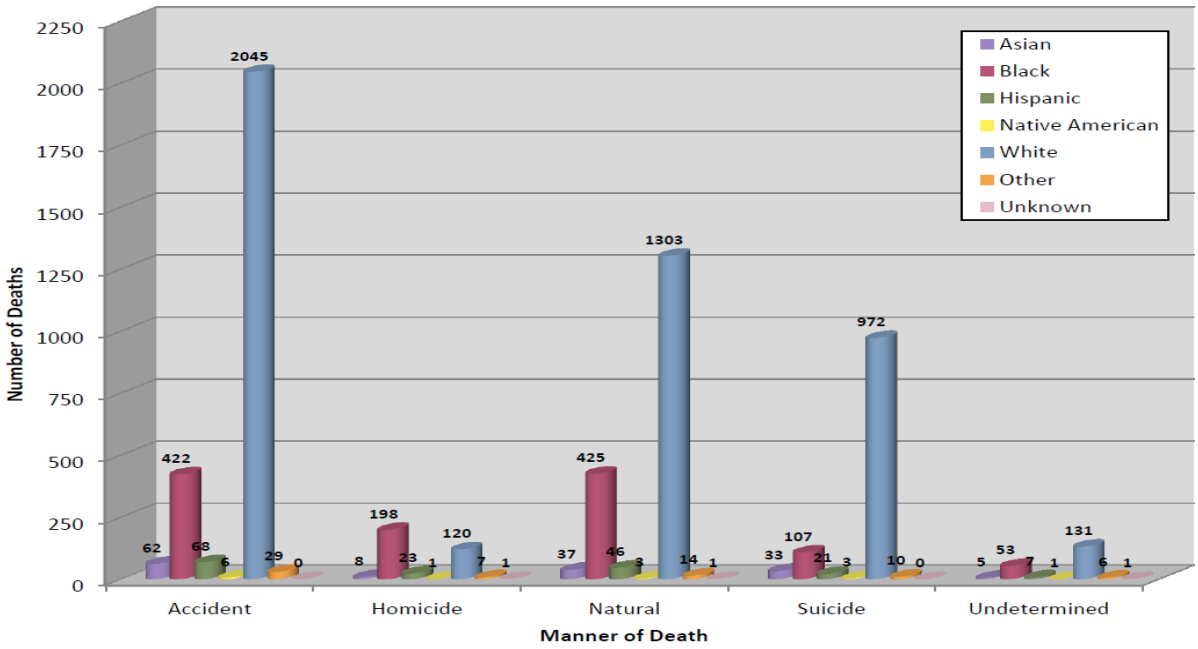


Table 1.6 Number and Percentage of OCME Cases by Manner of Death and Gender, 2014

	Manner of Death					
Gender	**Accident**	**Homicide**	**Natural**	**Suicide**	**Undetermined**	**Total**
Female	949 (15.4%)	94 (1.5%)	564 (9.1%)	259 (4.2%)	89 (1.4%)	**1952 (31.6%)**
Male	1683 (27.3%)	263 (4.3%)	1265 (20.5%)	887 (14.4%)	118 (1.9%)	**4216 (68.3%)**
Unknown	0 (0.0%)	1 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	**1 (0.0%)**
TOTAL	**2632**	**358**	**1829**	**1146**	**204**	**6169**

Gender	Age Group	Accident	Homicide	Natural	Suicide	Undetermined	Total
FEMALE	<1	15	3	15	0	31	64
	1-4	13	4	3	0	3	23
	5-9	5	4	0	0	1	10
	10-14	7	1	2	5	0	15
	15-19	20	6	5	13	1	45
	20-24	42	10	8	12	2	74
	25-34	109	16	28	35	3	191
	35-44	112	15	63	46	13	249
	45-54	113	15	110	65	11	314
	55-64	90	9	118	49	10	276
	65-74	79	8	92	23	7	209
	75-84	136	3	67	8	0	214
	85+	208	0	53	3	3	267
	Unknown	0	0	0	0	1	1
	Subtotal	949	94	564	259	86	1952
MALE	<1	19	4	6	0	53	82
	1-4	16	8	5	0	3	32
	5-9	11	3	3	0	0	17
	10-14	8	1	4	5	0	18
	15-19	53	26	3	45	2	129
	20-24	125	52	16	78	4	275
	25-34	270	71	68	147	8	564
	35-44	234	40	138	122	10	544
	45-54	282	27	301	168	15	793
	55-64	243	19	370	155	14	801
	65-74	125	9	232	91	4	461
	75-84	165	3	85	56	3	312
	85+	132	0	34	20	2	188
	Unknown	0	0	0	0	0	0
	Subtotal	1683	263	1265	887	118	4216
UNKNOWN	*Unknown*	0	1	0	0	0	1
	Subtotal	0	1	0	0	0	1
TOTAL		2632	358	1829	1146	204	6169

2014 GPWA Suicide

Locality	Number	Rate
PWC	37	8.3
MC	7	16.6
MPC	1	6.6

VDH OCME 2014 Annual Report

Highlights

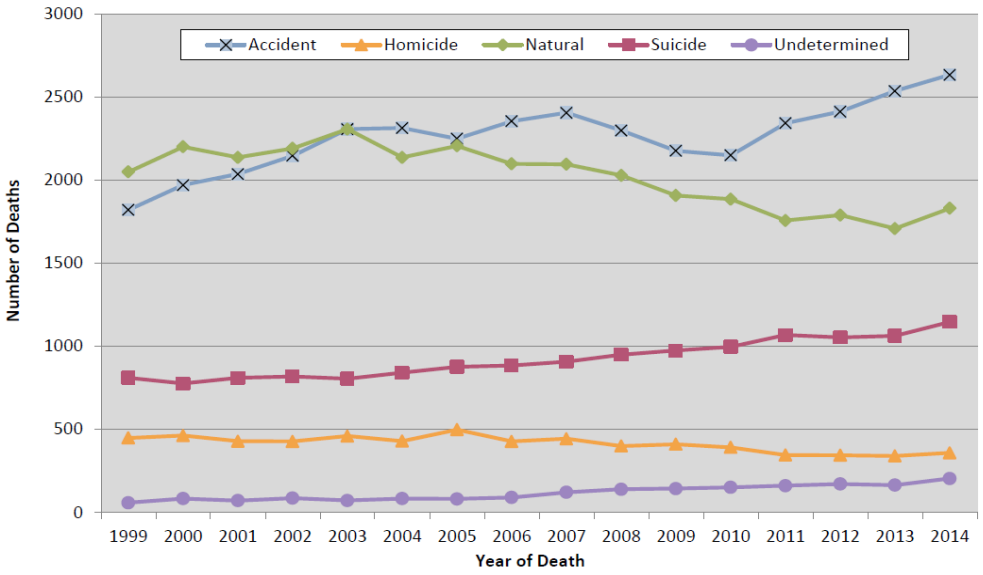
- Both community leaders and residents surveyed feel that mental health issues are one of the top most significant public health issues in the GPWA.
- The increasingly diverse population has made it even more difficult to address community mental health needs due to the lack of culturally appropriate mental health providers.
- In Northern Virginia, whites had the largest number of suicides.
- In Virginia, men were more likely to commit suicide than women at a rate of 14.4% vs 4.2%.
- In Virginia, women aged 35-64 had the highest risk of suicide, whereas for men it was age 25-64 years old.
- The increase in community substance use/abuse issues may be associated with a growing number of residents with untreated mental health disorders.
- Local Community Services feel that there is a need for more in-patient acute care beds in the GPWA and the region.
- The only state children's hospital available for the children in the GPWA is Commonwealth Children's in the Staunton area with limited capacity, therefore has moved toward a crisis stabilization method of care.

Suicide Rates

Suicide Deaths

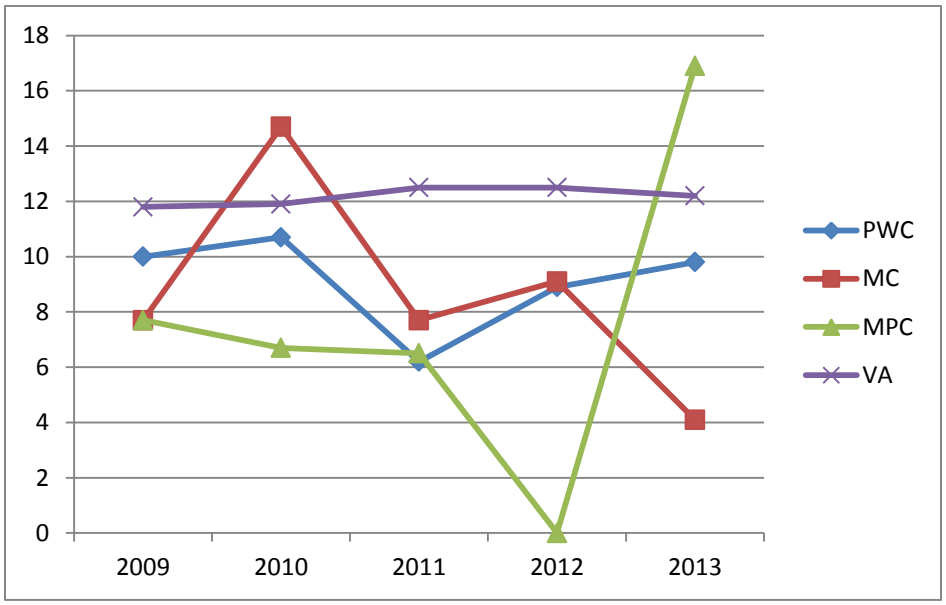
- The number of accidents, homicides, natural deaths, suicides, and undetermined deaths increased in 2014 compared to 2013.
- In 2014, White suicide rate was 6.4 times Hispanics, 3.1 times Asians, 2.8 times African American, and 1.6 times Native Americans.
- For the first time, in 2014, fatal drug overdoses became the most common cause of accidental death in Virginia.
- In general, the sucicide rate in the Prince William Health District is below the state rate except for in Manassas City in 2010 and Manassas Park City in 2013.
- There was a large increase in the suicide rate in Manassas Park City between 2012 (0.0) and 2013 (16.9).
- Both the community leaders and residents identified mental health and substance abuse as significant public health issues in the GPWA.

Figure 1.2 Number of OCME Cases by Manner of Death, 1999-2014



Office of the Medical Examiner (VDH) 2014 Annual Report

Suicide Rates from 2009-2013 in the GPWA



Suicide Rates 2009-2013 in the GPWA

	PWC	MC	MPC	VA
2009	10	7.7	7.7	11.8
2010	10.7	14.7	6.7	11.9
2011	6.2	7.7	6.5	12.5
2012	8.9	9.1	0	12.5
2013	9.8	4.1	16.9	12.2

VDH 2009-2013 Vital Statics Community Report

(PWC= Prince William County, MC = Manassas City, and MPC= Manassas Park City)

Oral Health

Oral diseases ranging from dental caries (cavities) to oral cancers cause pain and disability for millions of Americans. The impact of these diseases does not stop at the mouth and teeth. A growing body of evidence has linked oral health, particularly periodontal (gum) disease, to several chronic diseases, including diabetes, heart disease, and stroke. In pregnant women, poor oral health has also been associated with premature births and low birth weight. These conditions may be prevented in part with regular visits to the dentist. In 2007, however, only 44.5% (age adjusted) of people age 2 and older had a dental visit in the past 12 months, a rate that has remained essentially unchanged over the past decade.

Oral health is an essential part of staying healthy. Good oral health allows a person to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. Poor oral health has serious consequences, including painful, disabling, and costly oral diseases. Millions of Americans are living with one or more oral diseases, including:

Dental caries (cavities)
Periodontal (gum) disease
Cleft lip and palate
Oral and facial pain
Oral and pharyngeal (mouth and throat) cancers

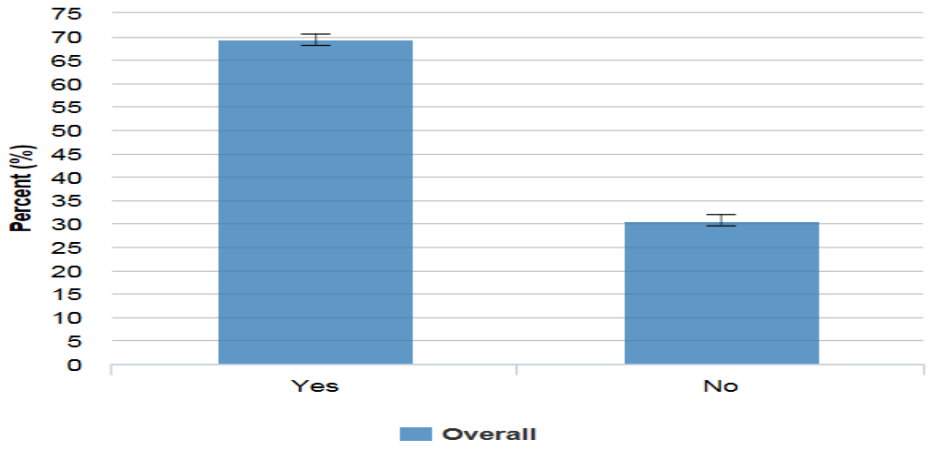
Gum disease, in particular, is associated with diabetes, heart disease, and stroke. In pregnant women, gum disease is also associated with premature births and low birth weight.
Oral Health, Healthy People 2020

3.8 million Virginians have no dental insurance. Most have nowhere to turn. Because they can't afford care, most simply go without. They suffer chronic pain, struggle to swallow or speak, and risk systemic infections and tooth loss. For some, the pain is so severe it interferes with their ability to work, to live a normal life, to smile.

While there are some "safety net" dentists providing care for low-income and uninsured adults, they are inundated with patients. And far too many Virginia communities have no dental safety net at all. In some rural areas, there is as few as one dentist for every 5000+ individuals.

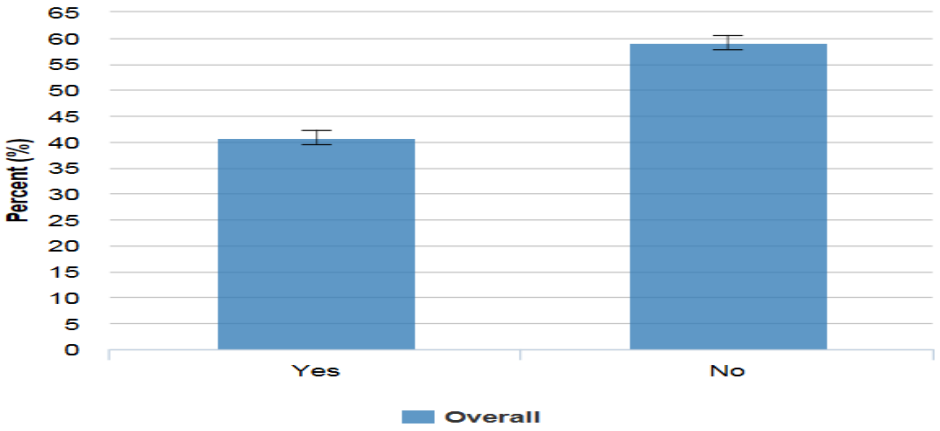
- 68 Virginia localities have no dental safety net provider.
- Although there now are 81 dental safety net sites in Virginia, many only offer care on a part-time basis. Although the need for dental care for adults is particularly acute, children also face obstacles obtaining care. FAMIS state-sponsored children's health insurance covers dental care, but Virginia still suffers from a significant shortage of pediatric dentists. VHCF.org

Virginia - 2014
Visited the dentist or dental clinic within the past year for any reason (variable calculated from one or more BRFSS questions) (Crude Prevalence)
View by: Overall
Response: (All)



Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Virginia - 2014
Adults that have had any permanent teeth extracted (variable calculated from one or more BRFSS questions) (Crude Prevalence)
View by: Overall
Response: (All)



Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

2014 GPWA Dentist per 100,000

Locality	Dentist per 100,000 population
PWC	48
MC	116
MPC	116
VA	64

Countyhealthrankings.org

Highlights

- In FY 15, the due to budget cuts, the state no longer provided funding for dental services through the Prince William Health District (PWHD).
- In FY15 and FY16, PWC provided local funding to support a part time dentist and full time dental assistant to provide care for children at or below 133% of the FPL and uninsured in the PWHD.
- In FY 17, PWHD discontinued dental care due to the significant decrease in the number of children seeking dental care in their clinic.
- There are twelve pediatric dental providers in the GPWA that accept Medicaid or FAMIS insurance.
- Greater Prince William Community Health Center has two of their three sites that provide dental care for both adults and children.
- Having health insurance does not guarantee affordable dental care or dental coverage at all.
- HealthLink provides access to low cost/free dental care for low-income, uninsured residents of Prince William County, Manassas of City, and Manassas Park. HealthLink recruits community-based dentists who provide care in their offices at 50% of the market rate for the area.
- There is little data on dental access to care for adults.

Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. STD prevention is an essential primary care strategy for improving reproductive health.

Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as:

Reproductive health problems
Fetal and perinatal health problems
Cancer
Facilitation of the sexual transmission of HIV infection

Why Is Sexually Transmitted Disease Prevention Important?

The Centers for Disease Control and Prevention (CDC) estimates that there are approximately 20 million new STD infections each year—almost half of them among young people ages 15 to 24. The cost of STDs to the U.S. health care system is estimated to be as much as $16 billion annually. Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the United States. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STDs cause at least 24,000 women in the United States each year to become infertile.

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 out of 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

In 2010, the White House released a National HIV/AIDS Strategy. The strategy includes 3 primary goals:

1. Reducing the number of people who become infected with HIV.
2. Increasing access to care and improving health outcomes for people living with HIV.
3. Reducing HIV-related health disparities.

Why Is HIV Important?

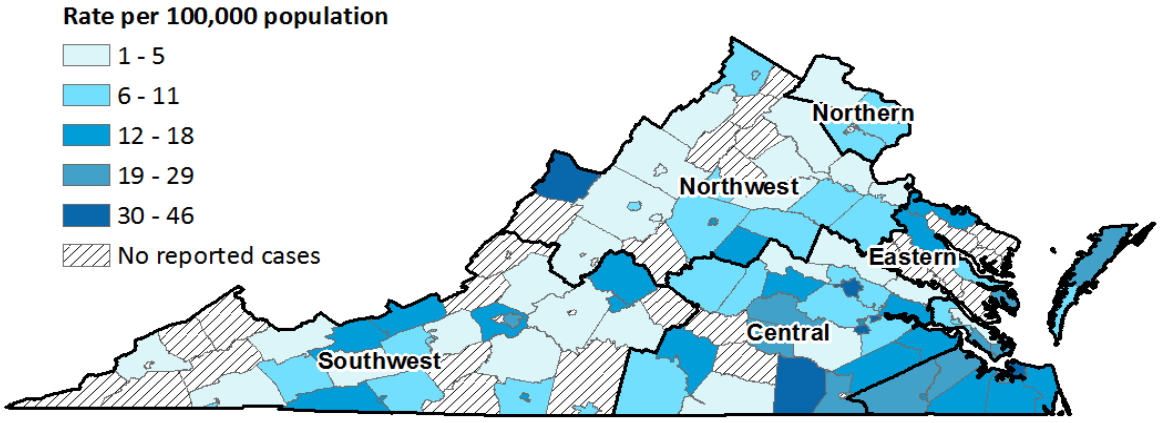
HIV is a preventable disease. Effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50 percent of new HIV infections occur as a result of the 21 percent of people who have HIV but do not know it.

There are several emerging issues in STD prevention:

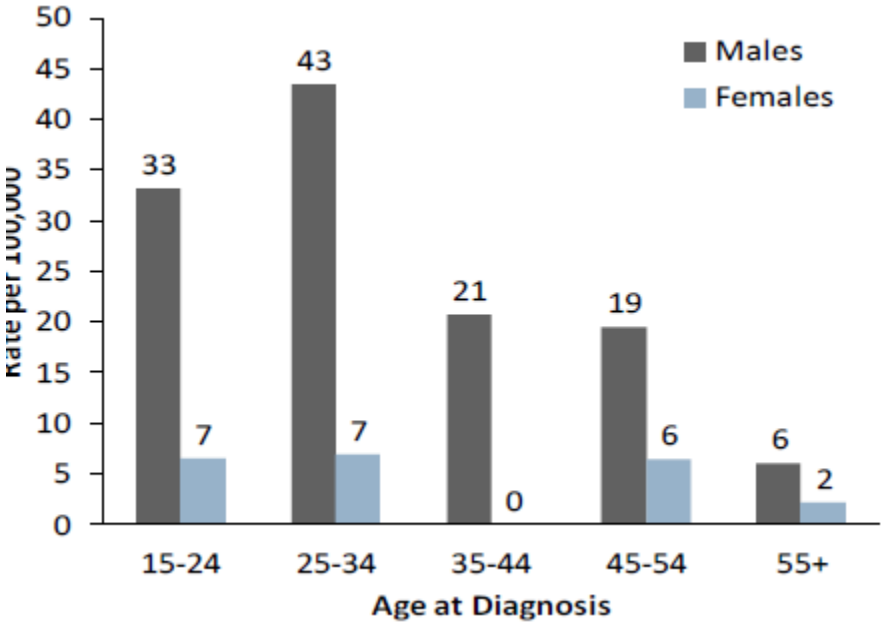
- Each state must address system-level barriers to timely treatment of partners of persons infected with STDs, including the implementation of expedited partner therapy for the treatment of chlamydial and gonorrheal infections.
- Enhanced data collection on demographic and behavioral variables, such as the sex of an infected person's sex partner(s), is essential to understanding the epidemiology of STDs and to guiding prevention efforts.
- Innovative communication strategies are critical for addressing issues of disparities, facilitating HPV vaccine uptake, and normalizing perceptions of sexual health and STD prevention, particularly as they help reduce health disparities.
- It is necessary to coordinate STD prevention efforts with the health care delivery system to leverage new developments provided by health reform legislation.

Sexually Transmitted Healthy People 2020

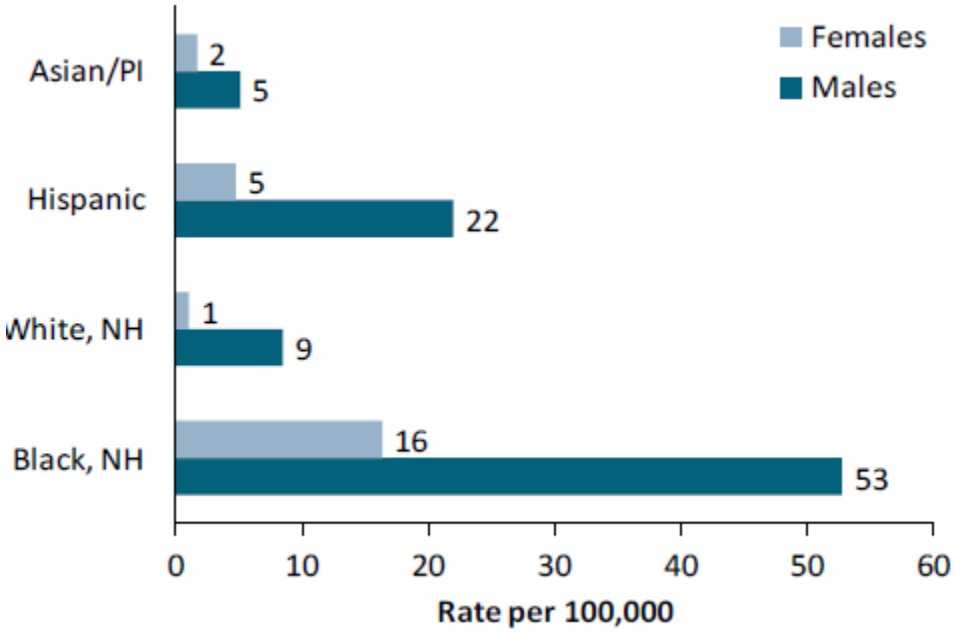
Newly Diagnosed Cases of HIV in Virginia 2015



Rate of Newly Diagnosed HIV Disease Cases by Age at Diagnosis and Gender, 2014

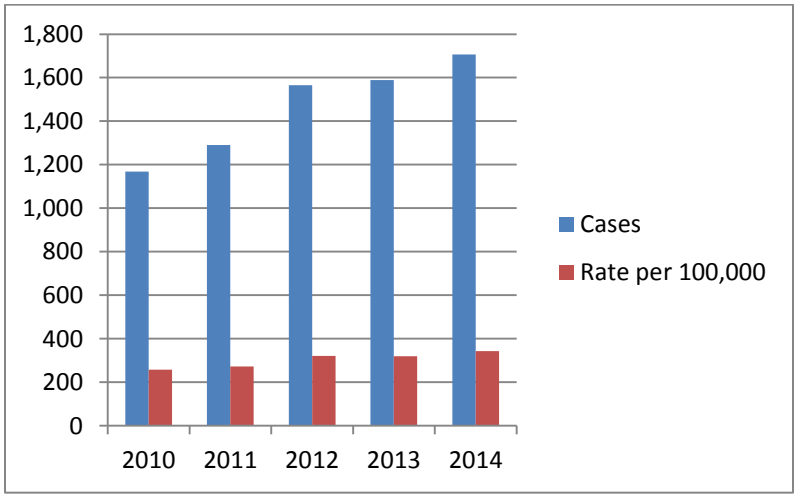


Rate of Newly Diagnosed HIV Disease Cases by Race/Ethnicity and Gender, 2014



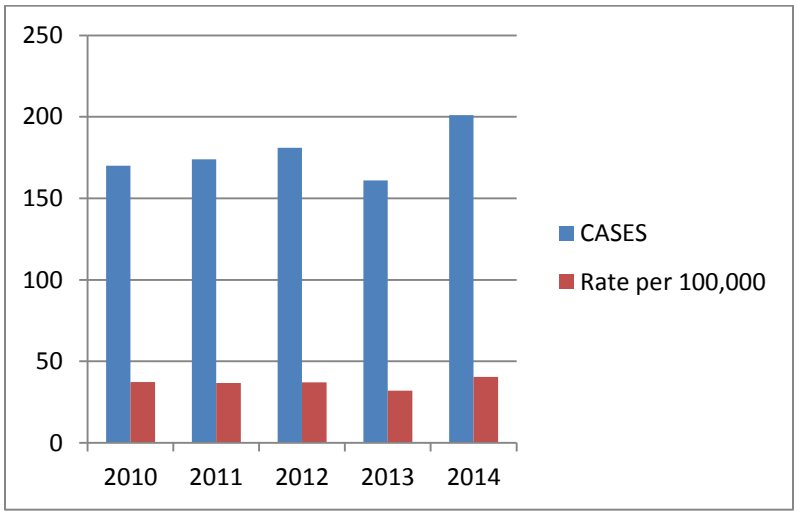
Chlamydia is a common sexually transmitted infection (STI) caused by the bacterium, **Chlamydia trachomatis**, which can damage a woman's reproductive organs. Even though symptoms of Chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia can cause discharge from the penis of an infected man.

GPWA Chlamydia Data



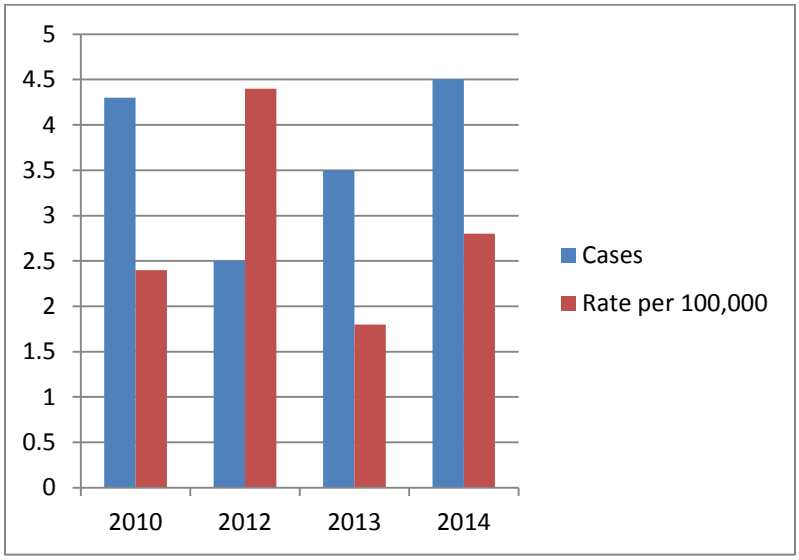
Gonorrhea is a common STD, also known as “the clap” or “the drip.” Gonorrhea, caused by the bacterium **Neisseria gonorrhea,** is spread through contact with the mouth, vagina, penis, or anus of an infected person. Gonorrhea lives in warm, moist areas of the body, including the tube that carries urine out of the body (urethra). The bacteria can even survive in the throat and eyelids. In women, the bacteria can grow in the reproductive tract (fallopian tubes, uterus, and cervix) and, if left untreated, can cause permanent reproductive damage, such as infertility.

GPWA Gonorrhea Rate



Syphilis is a sexually transmitted infection (STI) caused by the bacterium **Treponema pallidum**. It is known as "the great imitator" because so many of the signs and symptoms are indistinguishable from those of other diseases.

GPWA Syphilis Cases



2014 Annual VDH Health Statistics, Disease Prevention

Highlights

- Approximately 80% of the newly diagnosed HIV cases were among males, although the rate has stayed relatively stable 2005-2014.
- HIV cases among young adult population have increased in recent years.
- The greatest number of new HIV cases were in Black, Non-Hispanic.
- Most of the new cases HIV between 2005 and 2014 were between males having sex with males.
- The greatest number of new HIV cases were in males between age 25 and 34 years old.
- Chlamydia and gonorrhea cases have continued to rise from 2010 to 2014. Uncertain if this is a reflection of increased screening.
- The number of early syphilis cases in the district has risen dramatically between 2012 and 2014, over three times the number of cases in 2014 compared to 2012.

Substance Abuse

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95 percent of people with substance use problems are considered unaware of their problem.* Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Why Is Substance Abuse Important?

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

Teenage pregnancy
Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
Other sexually transmitted diseases (STDs)
Domestic violence
Child abuse
Motor vehicle crashes
Physical fights
Crime
Homicide
Suicide[1]

Understanding Substance Abuse

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Adolescent abuse of prescription drugs has continued to rise over the past 5 years. The 2007 survey found high rates of nonmedical use of the prescription pain relievers Vicodin and OxyContin. It is believed that 2 factors have led to the increase in abuse. First, the availability of prescription drugs is increasing from many sources, including the family medicine cabinet, the

Internet, and doctors. Second, many adolescents believe that prescription drugs are safer to take than street drugs.

Military operations in Iraq and Afghanistan have placed a great strain on military personnel and their families. This strain can lead to family disintegration, mental health disorders, and even suicide. Data from the Substance Abuse and Mental Health Services Administration (SAMSHA) National Survey on Drug Use and Health indicate that from 2004 to 2006, 7.1 percent of veterans (an estimated 1.8 million people) had a substance use disorder in the past year.

Healthy People 2020 Substance abuse

Alcohol

Excessive drinking

- Excessive alcohol use, either in the form of binge drinking (drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women) or heavy drinking (drinking 15 or more drinks per week for men, or 8 or more drinks per week for women), is associated with an increased risk of many health problems, such as liver disease and unintentional injuries.
- According to the ARDI application, from 2006–2010, excessive alcohol use was responsible for an annual average of 88,000 deaths, including 1 in 10 deaths among working-age adults aged 20-64 years, and 2.5 million years of potential life lost. More than half of these deaths and three-quarters of the years of potential life lost were due to binge drinking. www.cdc.gov

PRINCE WILLIAM COUNTY OVERVIEW

Measure	Sex	Value
Heavy drinking prevalence, 2012	Female	4.6%
Heavy drinking prevalence, 2012	Male	6.0%
Binge drinking prevalence, 2012	Female	9.4%
Binge drinking prevalence, 2012	Male	19.1%

2015 Institute for Health Metrics and Evaluation

Excessive Drinking: 2014

	PWC	MC	MPC	VA	HP2020 Goal
Drinking Excessively per 100,000	17.5%	17.1%	17.0%	16.6%	25.4%

Heavy Drinking at the State, Health Region, and Health District Levels, Virginia, 2011-2012-2013

1

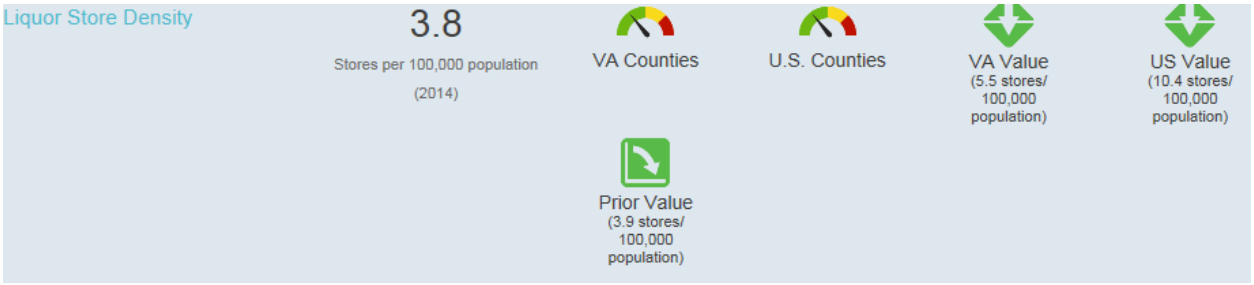
Virginia BRFSS Online Reporting System		Heavy Alcohol Consumption							
		No				Yes			
		Sample Size	Weighted Counts	Weighted Percent (%)	C.I. (95%)	Sample Size	Weighted Counts	Weighted Percent (%)	C.I. (95%)
*Virginia	*State Total	19877	5513650	94.2	93.8 -94.7	1142	338582	5.8	5.3 - 6.2
Central	*Region Total	3724	926804	93.3	92.1 -94.6	217	66113	6.7	5.4 - 7.9
	Chesterfield	687	252000	94.1	91.7 -96.5	39	15789	5.9	3.5 - 8.3
	Chickahominy	460	108256	95.1	92.7 -97.6	22	5530	4.9	2.4 - 7.3
	Crater	538	117508	93.1	89.1 -97.1	26	8734	6.9	2.9 -10.9
	Henrico	634	181403	92.7	89.9 -95.4	42	14356	7.3	4.6 -10.1
	Piedmont	494	95535	94.1	90.5 -97.6	22	6015	5.9	2.4 - 9.5
	Richmond City	472	102557	89.9	86.0 -93.7	48	11577	10.1	6.3 -14.0
	Southside	439	69546	94.4	90.0 -98.8	- - -	- - -	- - -	- - -
Eastern	*Region Total	4847	1259526	94.0	93.0 -95.0	278	80505	6.0	5.0 - 7.0
	Chesapeake	592	140596	94.3	90.7 -97.9	26	8434	5.7	2.1 - 9.3
	Eastern Shore	423	42549	94.2	89.8 -98.6	- - -	- - -	- - -	- - -
	Hampton	483	114233	94.7	92.3 -97.0	22	6453	5.3	3.0 - 7.7
	Norfolk City	601	132776	92.1	88.8 -95.3	51	11461	7.9	4.7 -11.2
	Peninsula	692	229659	95.0	93.0 -97.0	36	12039	5.0	3.0 - 7.0
	Portsmouth	308	49550	96.1	92.9 -99.3	- - -	- - -	- - -	- - -
	Three Rivers	557	152079	94.1	90.8 -97.4	29	9460	5.9	2.6 - 9.2
	Virginia Beach	686	283320	92.6	90.2 -95.0	59	22628	7.4	5.0 - 9.8
	Western Tidewater	505	114764	95.5	93.3 -97.7	24	5395	4.5	2.3 - 6.7
Northern	*Region Total	3900	1322711	93.8	92.8 -94.7	284	87777	6.2	5.3 - 7.2
	Alexandria	408	80568	89.5	85.7 -93.4	48	9420	10.5	6.6 -14.3
	Arlington	581	138920	92.2	89.7 -94.8	50	11706	7.8	5.2 -10.3
	Fairfax	1629	664060	94.2	92.9 -95.6	108	40688	5.8	4.4 - 7.1
	Loudoun	578	176311	93.6	90.6 -96.5	36	12097	6.4	3.5 - 9.4
	Prince William	704	262853	95.0	92.8 -97.2	42	13867	5.0	2.8 - 7.2

(Continued)

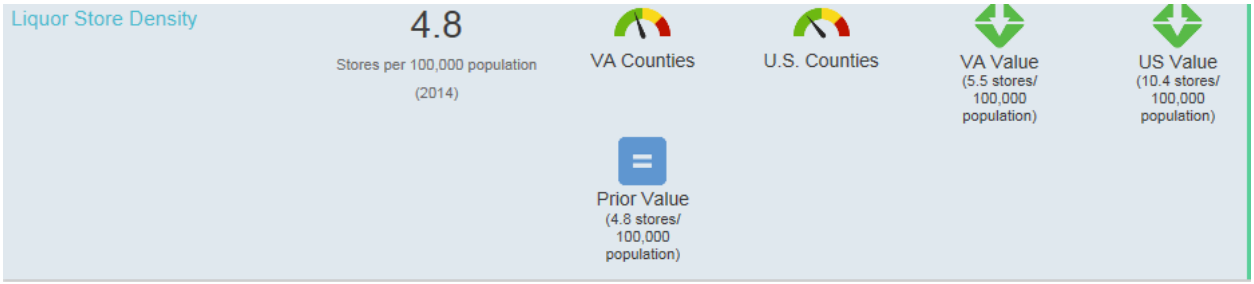
1. Data source: Virginia Department of Health, Division of Policy and Evaluation, Behavioral Risk Factor Surveillance Survey, 2011, 2012, & 2013 Combined. Weighted counts and weighted percents are weighted to population characteristics.
2. "- - -" replaces estimates when the unweighted sample size for the denominator was < 20 or the CI half width was > 10 for any cell.
3. Responses of don't know/not sure, refused, or missing were removed from the numerator and denominator in all estimates.
4. *** Use caution in interpreting sample sizes less than 50.
5. CI= 95% confidence interval.
6. *** Heavy drinkers (adult men having more than two drinks per day and adult women having more than one drink per day).

GPWA Liquor Store Density

PWC



MC



MPC-none

Alcohol-Impaired Driving Deaths (2010-2012) per 100,000 Population

PWC	MC	MPC	VA
22.5% ↓	0.0% ↓	100.0% —	31.2 %

Highlights:

- National average for binge drinking for females is 12.4% and males 24.5%.
- All jurisdictions had an excessive drinking percentage per 100,000 residents greater than the state, but met the HP2020 goal.
- The rate of alcohol-impaired driving deaths stayed the same or went down in the local jurisdictions.
- Manassas Park City the rate of alcohol- impaired driving deaths is more than three times the other jurisdictions and greater than the state.
- The built environment does not have excessive number of liquor stores in the GPWA.

Tobacco Use

Tobacco Indicators by Health District and Region, Virginia:
Current Smoking

Virginia Tobacco Use Control Project

Health District	All Adults (%)		Men	Women	Whites	Non-White or Hispanic	Ages 18-44	Ages 45-64	Ages 65 and older
VIRGINIA	20.2	95% CI: 19.5 - 20.9	22.1	18.5	19.8	21.4	24.1	19.8	8.3
North	14.1	12.5 - 16.0	15.9	12.3	12.4	18.3	16.4	12.9	6.9
Alexandria	17.5	14.0 - 21.7	21.0	14.0	14.6	25.0	21.2	13.2	9.7
Arlington	13.8	11.0 -17.3	18.0	9.4	12.6	18.4	16.3	11.5	9.5
Fairfax	11.8	9.1 - 15.1	14.1	9.3	9.3	17.2	12.5	12.5	5.5
Loudoun	13.1	10.7 - 16.0	12.2	14.0	12.4	16.5	15.2	10.6	7.0
Prince William	20.1	16.8 - 23.8	20.5	19.6	20.4	20.0	24.0	16.2	8.9

In Virginia, in 2013, smoking rates varied by subgroup Adults who had significantly higher smoking rates were:
• Male
• 25 to 34 years old
• Non-Hispanic Black
• Low income (e.g., less than $15,000)
• Those without a high school diploma
• Unemployed or unable to work
• Medically uninsured
• Physically, mentally or emotionally disabled
• In frequent mental distress*
• Binge drinker
• Physically inactive
• Suffering from chronic disease (asthma)

Disparities in Smoking in Virginia 2015

At this time, there is little or no data to estimate smoking prevalence among certain populations in Virginia. Findings from national surveys and other epidemiological studies indicate that the following groups have higher smoking prevalence rates:

• **Lesbians, gays and bisexuals (LGB) persons:** Prevalence of *every day* or *some day* use of any tobacco product was higher among LGB adults (30.8%) than heterosexual adults (20.5%). [3]

• **Persons with Mental Health or Substance Abuse Problems:** In Virginia the prevalence of current smoking† was 35.1% among adults with any mental illness* (AMI), compared with 19.7% of adults with no mental illness. [4] Adults who abuse alcohol or other drugs also have high smoking rates.

• **Homeless:** Sixty nine percent (69%) of homeless adults in the Richmond metro area smoke compared to 20% of non-homeless adults.[5]

• **Military Personnel:** Forty nine point two percent (49.2%) of military service members used a nicotine product* in the past 12 months. Nearly 1 in 4 (24.0%) of active duty military personnel currently smoke in comparison with the 19% of the non-military population.[6]

• **Prison Population:** The estimates of smoking prevalence among the prison population range from 50 to 83%.[7]

Updated by the Virginia Department of Health, Office of Family Health Services, Division of Prevention and Health Promotion, Tobacco Use Control Project on 1/23/2015.

GPWA 2014 Rates of Adults Who Smoke

	PWC	MC	MPC	VA	HP2020 Goal
Rate per 100,000	15.3	17.3	17.4	19.5	12.0

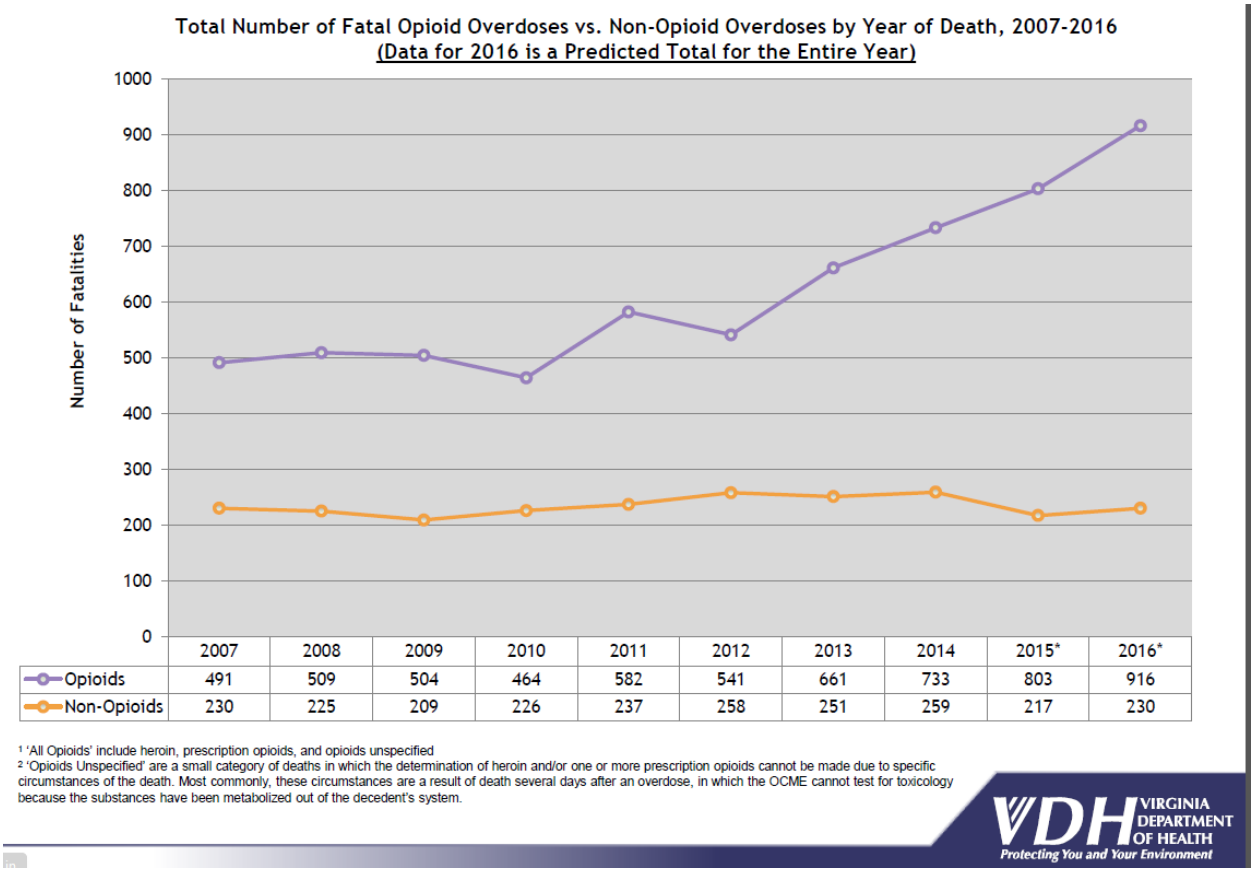
www.countyhealthrankings.org

Highlights:

- Tobacco use in the GPWA is approximately equal in males and females as well as White and Non-White residents in the community.
- Tobacco use was greatest between 18-44 year olds and gradually decreases as people age.
- Lung cancer death rates are lower in the GPWA than the state and meets the HP2020 goal of 45.5 per 100,000.

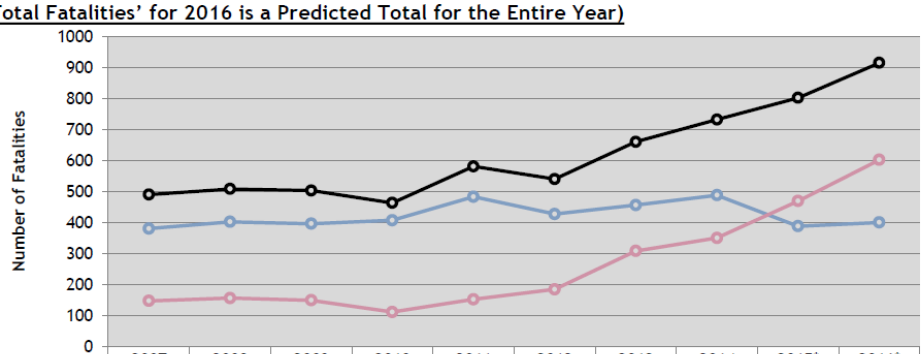
Drug Overdose

From 2007-2015, opioids (heroin and/or one or more prescription opioids) made up 70-75% of all fatal drug overdoses annually in Virginia. However, this percentage is increasing each year due to the significant increase in fatal fentanyl and/or heroin overdoses beginning in late 2013 and early 2014. Of the fatal opioid overdoses from 2007-2015, 26.9% had one or more benzodiazepines contributing to death.



Prescription opioids are drugs that are commercially made by pharmaceutical companies in certified laboratories that act upon the opioid receptors in the brain. Historically, fentanyl has been one of these drugs. However, in late 2013, early 2014, illicitly made fentanyl began showing up in Virginia and by 2016, most fatal fentanyl overdoses were of illicit production of the drug. Separating fentanyl from the grouping of prescription opioids for this reason demonstrates a decrease in fatal prescription opioid overdoses in 2015 and a dramatic increase in the number of fatal fentanyl and/or heroin overdoses. This has caused the momentous rise in all fatal opioid overdoses in the Commonwealth since 2012.

Total Number of Prescription Opioid (excluding Fentanyl), Fentanyl and/or Heroin, and All Opioid Overdoses by Year of Death, 2007-2016
('Total Fatalities' for 2016 is a Predicted Total for the Entire Year)



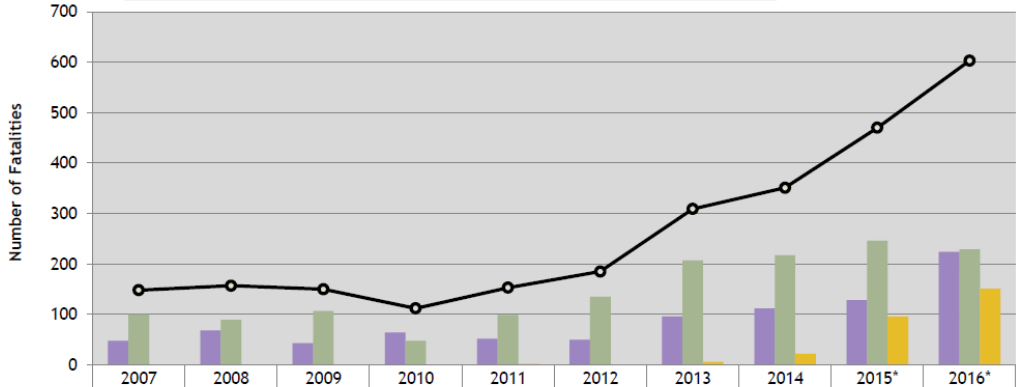
	2007	2008	2009	2010	2011	2012	2013	2014	2015*	2016*
All Opioids	491	509	504	464	582	541	661	733	803	916
Prescription Opioids (excluding fentanyl)	381	403	397	408	484	428	457	489	389	401
Fentanyl and/or Heroin	148	157	150	112	153	185	309	351	470	603

[1] 'All Opioids' include heroin, prescription opioids, and opioids unspecified
[2] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)
[3] 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescriptions opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these prescription opioids.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

The total number of fatal fentanyl and/or heroin overdoses have significantly increased since late 2012. It is important to look at these two drugs together because as heroin became more popular in 2010, fentanyl occasionally began showing up as an additive to the heroin. By late 2013 and early 2014, some heroin being sold on the street was actually completely fentanyl, unbeknownst to the user. It is essential to look at these fentanyl (no heroin), heroin (no fentanyl), and fentanyl and heroin combination deaths together because users never know exactly what is in the illegal drugs they buy off the streets.

Total Number of Fatal Fentanyl and/or Heroin Overdoses by Year of Death, 2007-2016
('Total Fatalities' for 2016 is a Predicted Total for the Entire Year)

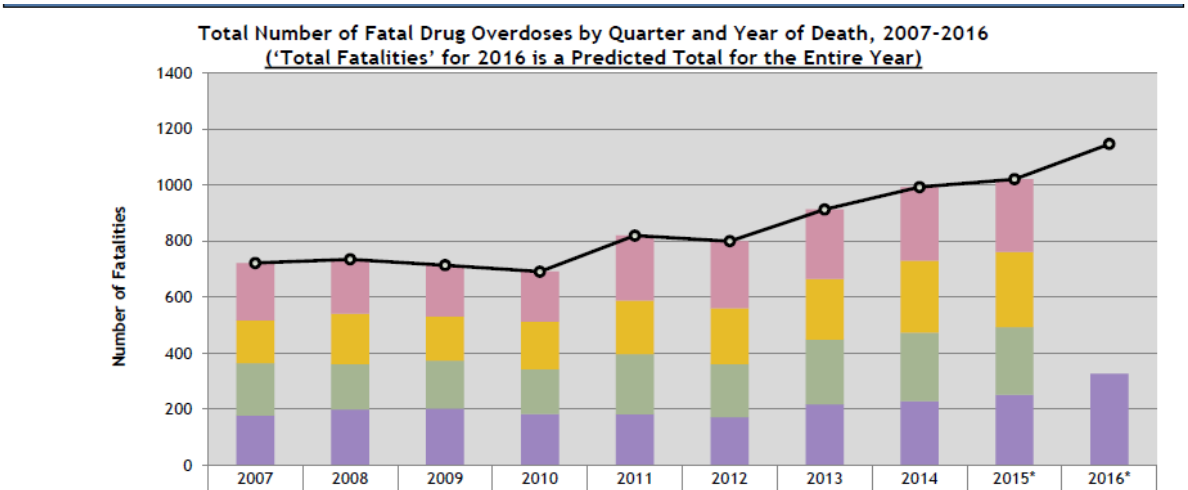


	2007	2008	2009	2010	2011	2012	2013	2014	2015*	2016*
Fentanyl	48	68	43	64	52	50	96	112	128	224
Heroin	100	89	107	48	99	135	207	217	246	229
Fentanyl and Heroin	0	0	0	0	2	0	6	22	96	151
Total Fatalities	148	157	150	112	153	185	309	351	470	603

[1] Historically, fentanyl has been categorized as a prescription opioid because it is mass produced by pharmaceutical companies. However, recent law enforcement investigations and toxicology results have demonstrated that several recent fentanyl seizures have ***not*** been pharmaceutically produced, but illicitly produced. This illicit form of fentanyl is produced by international drug traffickers who import the drug into the United States and often, mix it into heroin being sold. This illicitly produced fentanyl , especially fentanyl mixed with heroin, has been the biggest contributor to the significant increase in the number of fatal opioid overdoses in Virginia.
[2] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)

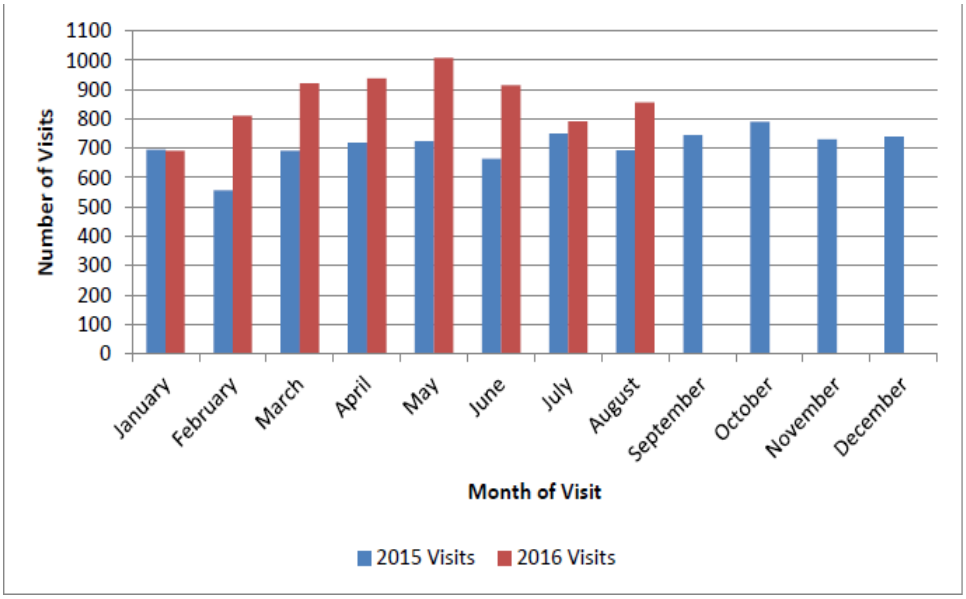
VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

The total number of fatal drug overdoses statewide have been increasing each year. In 2013, fatal drug overdose became the number one method of unnatural death in the Commonwealth, surpassing both motor vehicle-related fatalities and gun-related fatalities. In 2014, fatal drug overdose became the leading cause of accidental death in Virginia. The first quarter of 2016 had a 29.5% increase in the number of fatal drug overdoses compared to the same time frame (first quarter) of 2015.



	2007	2008	2009	2010	2011	2012	2013	2014	2015*	2016*
Q4	205	194	183	179	232	240	248	262	260	
Q3	152	180	157	170	191	199	217	257	268	
Q2	188	162	172	159	215	190	230	245	241	
Q1	176	198	201	182	181	170	217	228	251	325
Total Fatalities	721	734	713	690	819	799	912	992	1020	1146

Emergency Department Visits for Unintentional Drug and Heroin Overdoses among Virginia Residents, January 2015 – August 2016 Report Generated: September 9, 2016
Chief complaints and discharge diagnoses of emergency



www.vdh.virginia.gov/VDH Enhanced Surveillance Monthly Report

Rate of ED Visits with Chief Complaint or Discharge Diagnosis of Unintentional Heroin Overdose among Virginia Residents by Health District and Month, Previous 12 Months of 2015-2016

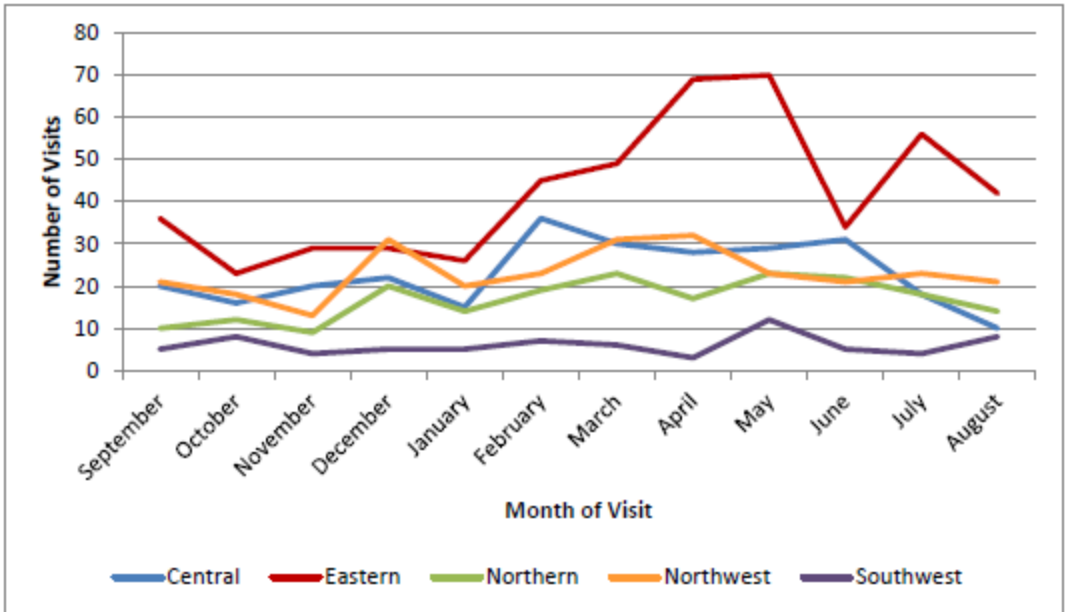
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Jun	July	August
PWHD	0.79	0.79	0.60	0.20	1.19	1.19	0.79	0.20	1.39	1.59	0.79	0.99

www.vdh.virginia.gov/VDH Enhanced Surveillance Monthly Report

(Population Estimate based on 2015 census population estimate: 503,349 PWC, MC, MPC)

Number of ED Visits with Chief Complaint or Discharge Diagnosis of Unintentional Heroin Overdose among Virginia Residents by Month and Region, Previous 12 Months of 2015-2016

Inclusion terms from either Chief Complaint or Discharge Diagnosis: heroin, herion, 965.01, T40.1X1A, T40.1X4A
Exclusions terms from Chief Complaint only: withdrawl, withdrawal, detox



www.vdh.virginia.gov/VDH Enhanced Surveillance Monthly Report

GPWA Fatal Overdoses Rate (2014)

Locality of Injury	Fatal Heroin Overdose	Fatal Prescription Opioid Overdoses	Fatal Cocaine and/or Heroin Combination Death
PWC	2.5	4.5	3.6
Manassas City	9.5	16.6	11.9
Manassas Park City	13.2	0.0	6.6

Injury

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable. The Injury and Violence Prevention objectives for 2020 represent a broad range of issues which, if adequately addressed, will improve the health of the Nation.

Why Is Injury and Violence Prevention Important?

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

Premature death
Years of potential life lost
Disability and disability-adjusted-life-years lost
Poor mental health
High medical costs
Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities. Healthy People 2020 Injury and Violence

In Virginia, accidents accounted for 42.7% of the deaths investigated by the OCME in 2014, which is the greatest proportion of deaths by any manner.

- The total number of accidental deaths increased 3.8% from 2013
- For the first time on record, fatal drug overdoses became the most common cause of accidental death (30.1%), followed by accidental motor vehicle deaths (29.9%)
- Seniors 85 years and older had the highest mortality rate due to falls (209.6 per 100,000 persons)

- Of the nearly 80% of decedents of accidental death who were tested for ethanol, 25.6% had ethanol detected through toxicology testing. Of those tested, 17.6% had a blood alcohol level of 0.08% BAC or greater; the level of legal intoxication.

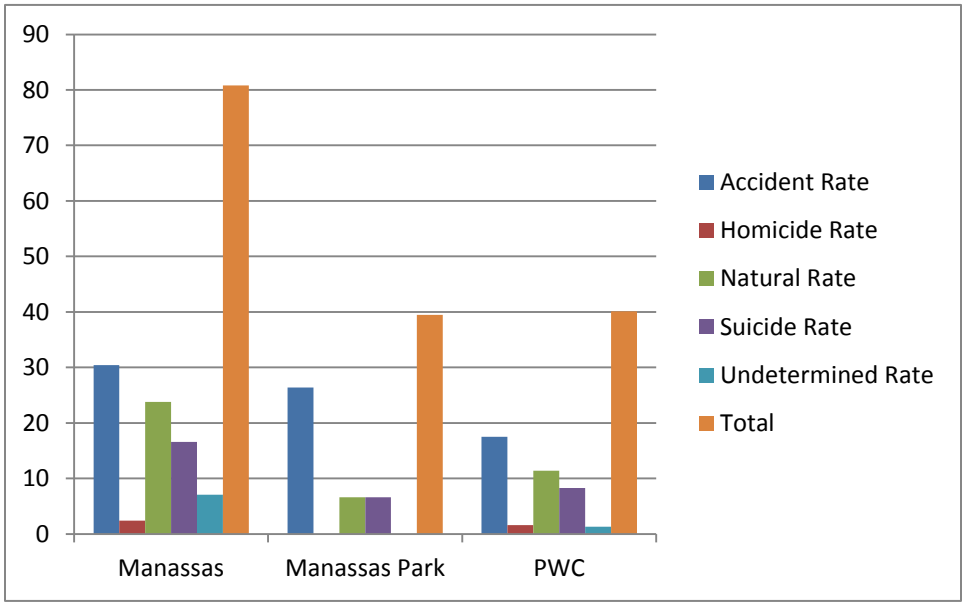
VDH Medical Examiner's Annual report 2014

Table 2.2 Number and Rate of the Top 5 Accidental Methods of Death by Age Group, 2014

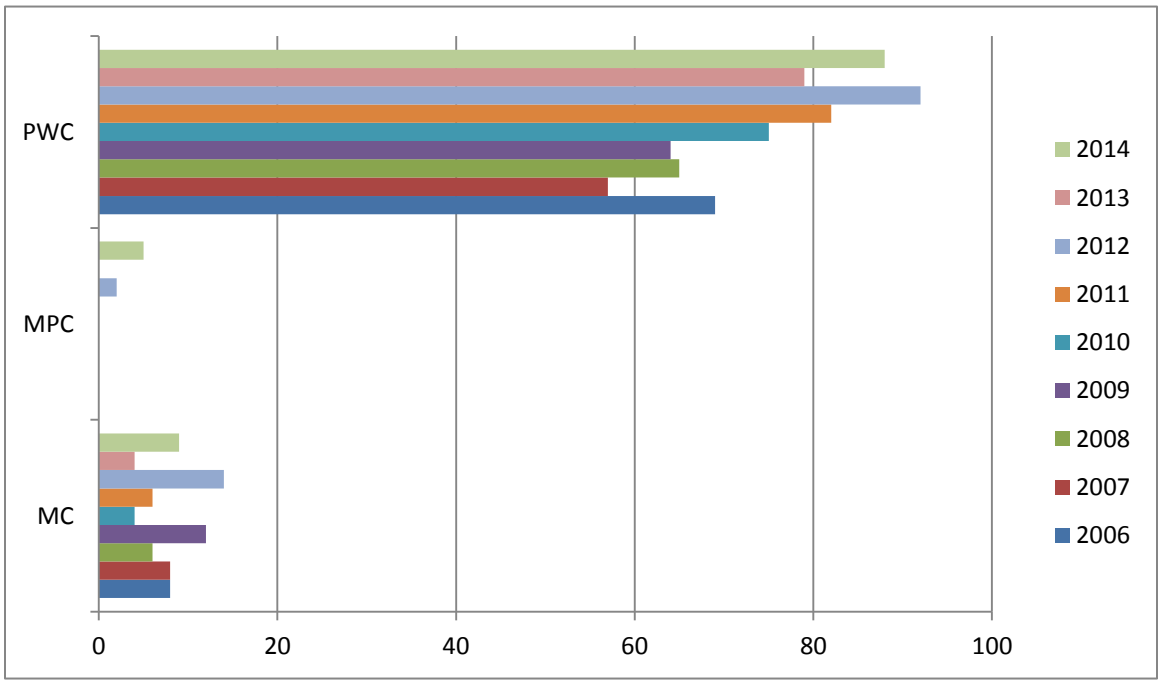
Age Group	Drowning		Drug Use		Fall		Fire/Smoke Inhalation		Motor Vehicle Collision		TOTAL
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	
<1	0	0.0	0	0.0	0	0.0	2	1.9	4	3.9	6
1-4	8	1.9	0	0.0	0	0.0	5	1.2	5	1.2	18
5-9	5	1.0	0	0.0	0	0.0	2	0.4	6	1.2	13
10-14	1	0.2	0	0.0	0	0.0	1	0.2	11	2.1	13
15-19	3	0.6	12	2.2	1	0.2	2	0.4	51	9.5	69
20-24	8	1.3	63	10.4	3	0.5	2	0.3	83	13.7	159
25-34	14	1.2	210	17.9	5	0.4	5	0.4	131	11.1	365
35-44	8	0.7	208	19.1	13	1.2	4	0.4	91	8.4	324
45-54	15	1.3	186	15.8	32	2.7	8	0.7	130	11.1	371
55-64	8	0.8	99	9.5	56	5.4	10	1.0	125	12.0	298
65-74	6	0.9	12	1.8	79	11.6	14	2.1	67	9.9	178
75-84	0	0.0	1	0.3	207	62.9	15	4.6	59	17.9	282
85+	2	1.4	0	0.0	291	209.6	4	2.9	25	18.0	322
TOTAL	**78**	**0.9**	**791**	**9.5**	**687**	**8.3**	**74**	**0.9**	**788**	**9.5**	**2418**

VDH Medical Examiner's Annual report 2014

GPWA Rates of OCME Cases by Manner of Death (2014)



GPWA Number of Accidental Deaths by Locality and Year of Death (2006-2014)



GPWA Hospitalization Accidental Injury Data 2011-2014

Year	Number	Population	Avg. LOS	Avg. Cost	Total Cost	Rate	Age Adjusted Rate
2011	907	473,630	4.13	$30,022	$29,251,725	191.50	281.13
2012	955	486,692	4.01	$30,669	$31,660,813	196.12	275.54
2013	885	496,436	4.01	$33,387	$32,615,848	178.27	250.89
2014	851	503,349	4.39	$40,425	$36,915,849	170.26	236.00

LOS=length of stay

GPWA Motor Vehicle Hospitalization Injury Data 2011-2014

Year	Number	Population	Avg. LOS	Avg. Cost	Total Cost	Rate	Age Adjusted Rate
2011	149	473,638	5.97	$47,245	$7,226,705	31.46	33.17
2012	161	486,692	5.16	$40,848	$7,437,202	33.08	35.27
2013	147	496,434	6.13	$56,651	$8, 287,722	29.61	31.07
2014	133	503,349	5.69	$66,560	$9,915,521	26.42	28.03

Highlights

- The total number of accidental deaths have increased in the state, but the numbers have been relatively stable in the GPWA.
- The greatest number of deaths in the GPWA is accidental deaths.
- Although the number of accidental deaths in the GPWA has been relatively stable, the total hospitalization costs have dramatically increased.
- Accidental deaths are the most common cause of death in the GPWA.
- In Virginia in 2014:
  - This is the first time on record that drug overdose fatalities was the most common cause of accidental deaths.
  - Drowning was the most common cause of accidental death in 1-4 year olds.
  - Drug overdose was the most common cause of accidental death in 35-44 year olds.
  - Fire/Smoke inhalation was the most common cause of accidental death in 75-84 year olds.
  - Falls were the most common cause of accidental death in 85+ year olds.
  - Motor Vehicle Accident deaths were most common in 85+ year olds.

Physical Activity

The Physical Activity objectives for Healthy People 2020 reflect the strong state of the science supporting the health benefits of regular physical activity among youth and adults. Regular physical activity includes participation in moderate and vigorous physical activities and muscle-strengthening activities.

More than 80 percent of adults do not meet the guidelines for both aerobic and muscle-strengthening activities. Similarly, more than 80 percent of adolescents do not do enough aerobic physical activity to meet the guidelines for youth. Working together to meet Healthy People 2020 targets via a multidisciplinary approach is critical to increasing the levels of physical activity and improving health in the United States. Physical activity levels are impacted by our structural environments, such as the availability of sidewalks, bike lanes, trails, and parks, as well as legislative policies that improve access to facilities that support physical activity

Why Is Physical Activity Important?

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of:

- Early death
- Coronary heart disease
- Stroke
- High blood pressure
- Type 2 diabetes
- Breast and colon cancer
- Falls
- Depression

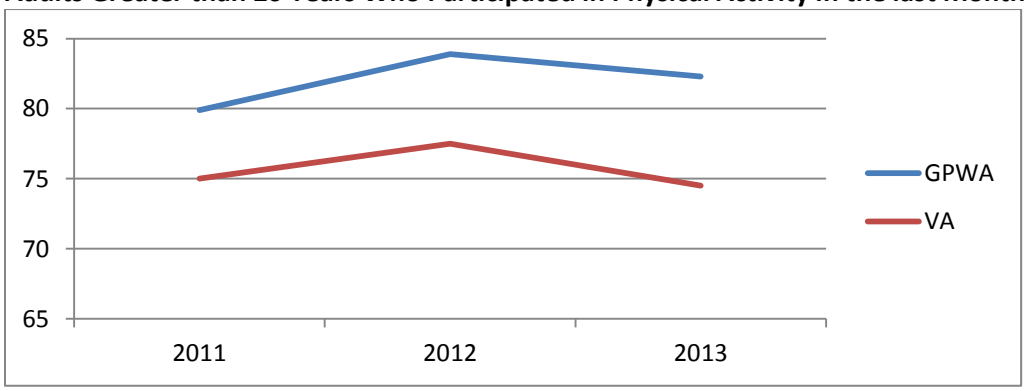
Healthy People 2020 Physical Activity

Positive Associations with Adequate Exercise	Negative Associations with Adequate Exercise
Postsecondary education	Advancing age
Higher income	Low income
Enjoyment of exercise	Lack of time
Expectation of benefits	Low motivation
Belief in ability to exercise (self-efficacy)	Rural residency
History of activity in adulthood	Perception of great effort needed for exercise
Social support from peers, family, or spouse	Overweight or obesity
Access to and satisfaction with facilities	Perception of poor health
Enjoyable scenery and safe neighborhoods	Being disabled

A study from the Division of Nutrition, Physical Activity, and Obesity on physical inactivity among adults aged 50 and older.
The study found that approximately 31 million adults in this age group (28%) are inactive. Other key findings include:

- Inactivity was higher for women (29.4%) compared to men (25.5%).
- Inactivity varied by race and ethnicity and was 32.7% for Hispanics, 33.1% for non-Hispanic blacks, 26.2% for non-Hispanic whites, and 27.1% for other groups.
- Inactivity significantly increased by age groups and was 25.4% for adults 50-64 years, 26.9% for those 65-74 years, and 35.3% for those 75 years and older.
- More adults with at least one chronic disease were inactive (31.9 %) compared to adults with no chronic disease (19.2%).
- By region, inactivity was highest in the South (30.1%) followed by the Midwest (28.4%) and the Northeast (26.6 %). Inactivity was lowest in the West (23.1%).
- By states and the District of Columbia, the percentage of inactivity ranged from 17.9% in Colorado to 38.8% in Arkansas. CDC's Morbidity and Mortality Weekly Report (*MMWR)*

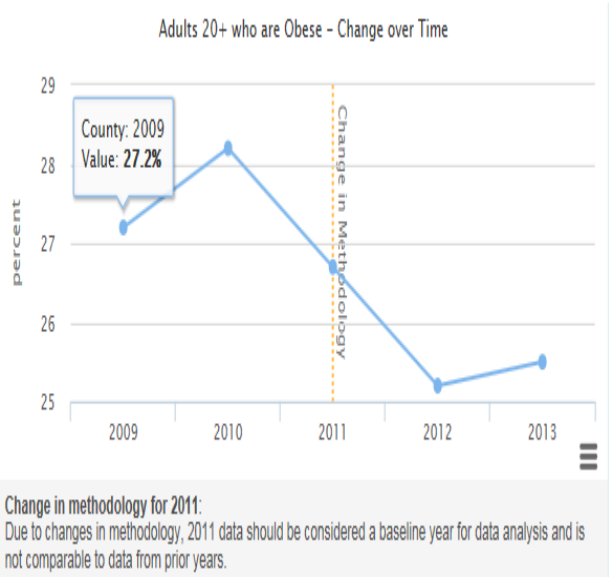
Adults Greater than 20 Years Who Participated in Physical Activity in the last Month

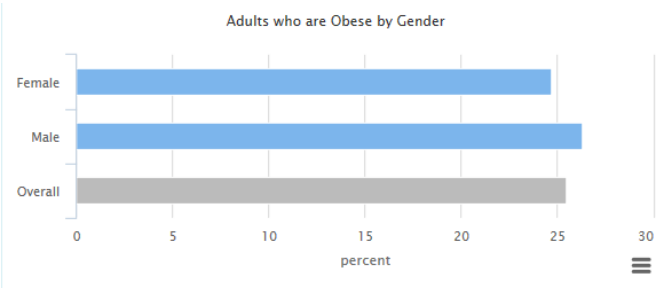


BRFSS data for 2011-2013

Obesity

PWC





Nutrition

The Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities.

Why Are Nutrition and Weight Status Important?

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions

Individuals who are at a healthy weight are less likely to:

Develop chronic disease risk factors, such as high blood pressure and dyslipidemia.
Develop chronic diseases, such as type 2 diabetes, heart disease, osteoarthritis, and some cancers.
Experience complications during pregnancy.
Die at an earlier age

Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity. Healthy People 2020 Nutrition and Weight Status

Although the PWHD does not have any food deserts, there are other economic and environmental factors that impact the nutritional status of the families living in the community. The data on the PWHD does not show evidence of food insecurity in children or families. This is due to the various programs and sites that provide food for those in need. Unfortunately, the number of SNAP certified stores has decreased in the community from 2010 to 2014. The percentage of children receiving free lunch has increased in all three local jurisdictions, and is greater than the state. Unexpected data due to the high median income of the district. Some good news, the low income preschool obesity rate in PWC has decreased from 24.80% to 21.1%.

The distance residents travel, and time spent on the road to and from work, greatly impacts the ability or desire for families to make home cooked meals. Additionally, in Manassas City the density of fast food establishments is significantly greater than the two other local jurisdictions. Fast food is often high in fat and calories and lacking in recommended nutrients. Frequent consumption of these foods and an insufficient consumption of fresh fruits and vegetables increase the risk of overweight and obesity. Individuals who are overweight or obese are at increased risk for serious health conditions, including coronary heart disease, type-2 diabetes, multiple cancers, hypertension, stroke, premature death and other chronic conditions. Fast food outlets are more common in low-income neighborhoods and studies suggest that they strongly contribute to the high incidence of obesity and obesity-related health problems in these communities. BeHealthyBeHappyPrinceWilliam.com

The severe housing problem due to the cost of housing in the community is greater than other parts of the state as a whole. Therefore, a greater percentage of a family's income is dedicated to housing, and less is available for healthy foods, which tend to cost more money.

Vitamin and Mineral Intake

According to multiple studies done recently, majority of Americans do not get adequate amounts of recommended vitamins or minerals in their daily diets. Most concerning is adequate amounts of calcium, potassium, dietary fiber, and vitamin D. Additionally, iron intake is a concern for young children and reproductive women. National Health and Nutrition Examination Survey (NHANES) done from 2007-2010, showed that individuals 4 years old and older consumed less than the estimated average requirement of vitamin D and E. More recently, US Department of Health and Human Services and Agriculture released guidelines in January of 2016 that identified potassium vitamin D, calcium, dietary fiber, and iron intake below the estimated average requirement.

In the US, non-Hispanic Blacks have higher rates of vitamin B6, which is associated with a type of anemia, dermatitis, depression, and weakened immune system. Non-Hispanic blacks and Mexicans are more likely to have a vitamin D deficiency and iron deficiency.

Dietary intake is the best way to obtain essential vitamins and nutrients, but vitamin and mineral supplements have shown to increase nutrient intake and is more often associated with better health choices. Eating a healthy diet can be a challenge due to inadequate access to healthy foods due to location or cost and acculturation of PWHD residents. September 2016 OBG Management Supplement

Economic and Environmental Impacts on Nutrition (2010-2014)

Indicator	PWC	MC	MPC	VA
Child Food Insecurity	11.2%	13.9%	12.0%	16%
Food Insecurity	6.9%	7.2%	6.1%	11.8%
Fast Food Density per 1000 population	.63	1.21	.51	_____
SNAP Certified Stores per 1000 population	.40	.90 ↓	.50 ↓	_____
Percent of Children Receiving Free Lunch	33.3 ↑	45.4 ↑	49.1 ↑	32.1
Severe Housing Problems	15.9%	21.0%	17.8%	15.4%
Mean Travel Time to Work One Way in Minutes	39.3	33.5	40.4	27.8

Highlights

- Child food insecurity percentage is lower than the state, although the number of children getting free lunch in the district has increased. This school lunch program and the expansion of the Summer Feeding program has help to ensure our children are being fed.
- In PWC, the percentage of low income children who are obese has decreased from 24.8 to 21.1 percent.
- The percentage of obese adults has increased from 2011 to the present.
- The percentage of adults over twenty years old that have been physically active in the last month is decreasing.

Comparison To Healthy People 2020

Healthy People 2020 aim is to reach four overarching goals:

1. Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity, eliminate disparities, and improve the health of all groups.
3. Create social and physical environments that promote good health for all. cdc.gov

Healthy People provide science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

Encourage collaborations across communities and sectors.
Empower individuals toward making informed health decisions.
Measure the impact of prevention activities.

Vision

A society in which all people live long, healthy lives.

Mission

Healthy People 2020 strive to:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state, and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs. Healthy People 2020

Healthy People 2020 Comparison

Indicator	PWC	MC	MPC	HP2020
% Adults with Health Insurance	89.4 (2014)	76.0 (2014)	75.4 (2014)	100%
% Children with Health Insurance	93.1 (2014)	90.4 (2014)	89.9 (2014)	100%
Age Adjusted Death Rate for Breast Cancer	20.6 (2009-2013)	24.5 (2009-2013)	No data	20.7 per 100,000 female population
Age Adjusted Death Rate for Colorectal Cancer	12.3 (2009-2013)	17.8 (2009-2013)	44.5 (2009-2013)	14.5 per 100,000 population
Age Adjusted Death Rate for Lung Cancer	40.9 (2009-2013)	38.8 (2009-2013)	42.0 (2009-2013)	45.5 per 100,000 population
Age Adjusted Death Rate for Prostate Cancer	21.5 (2009-2013)	43.4 (2009-2013)	No Data	21.8 per 100,000 male population
Percent Adult Over 20 yo Obesity Rate	25.5	28.7	28.3	30.5%
Percent Adult Over 20 yo Sedentary	16.4	20.1	21.1	32.6%
Age Adjusted Stroke Death Rate	27.2	40.7	25.0	34.8 per 100,000 population
Low Birth Weight	7.5	7.6	0.0	7.8%
Infant Mortality Rate	6.0 (2013)	6.6 (2013)	0.0	6.0 per 1000 live births
Early Prenatal Care	80.4	75.9	68.4	77.9 %
Age Adjusted Suicide Death Rate	9.8	4.1	16.9	10.2
Age Adjusted Unintentional Injury Death Rate	26.1	12.7	7.1	36.4
Percent Adult who Drinks in Excess	17.5 (2014)	17.1 (2014)	17.0 (2014)	25.4%
Percent Adults who Smoke	15.3 (2014)	17.3 (2014)	17.4 (2014)	12.0%
High School Graduation Rate	91.4 (2015)	85.9 (2015)	87.9 (2015)	82.4%

Chronic Disease and Hospitalization Data

Preventable Hospitalizations

The measure of preventable hospitalizations in a community indicates the quality and accessibility of primary health care services available. If the quality of care in the outpatient setting is poor, then people may be more likely to overuse the hospital as a main source of care and be hospitalized unnecessarily. An area with a higher density of primary care providers usually has lower rates of hospitalization for preventable hospitalizations.

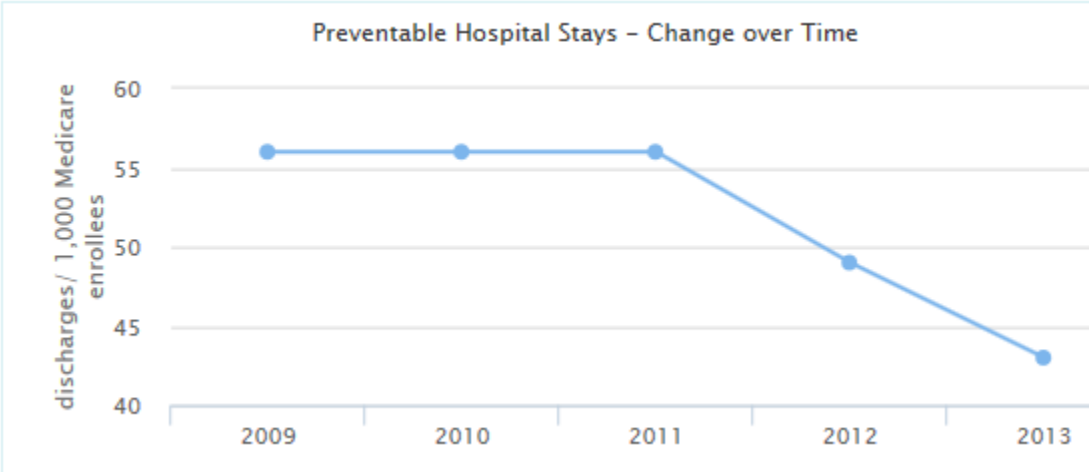
behealthybehappyprincewilliam.com

Almost a quarter of the district population is uninsured therefore access to ongoing primary care can be limited. Often these residents seek care only when they are in crisis, therefore, increasing the number of preventable hospital stays as well as healthcare costs. Many of the uninsured adults do not work normal daytime hours, and may travel all over the National Capitol Region to work. This is another reason these residents may have limited access to continuous primary care.

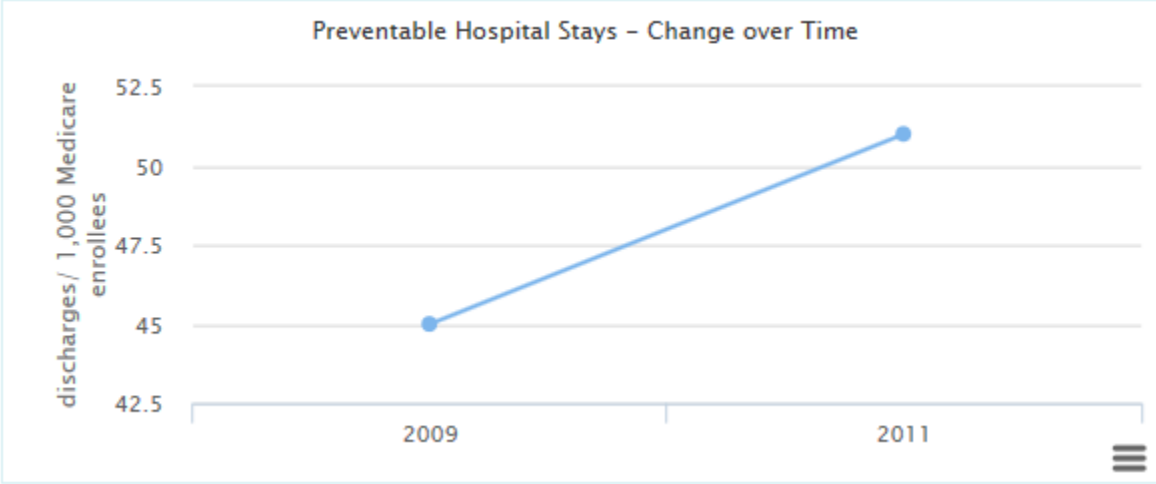
Discharge per 1000 Medicare Enrollees

PWC	MC	MPC
43 (2013)	51 (2013)	41 (2013)
49	45	50

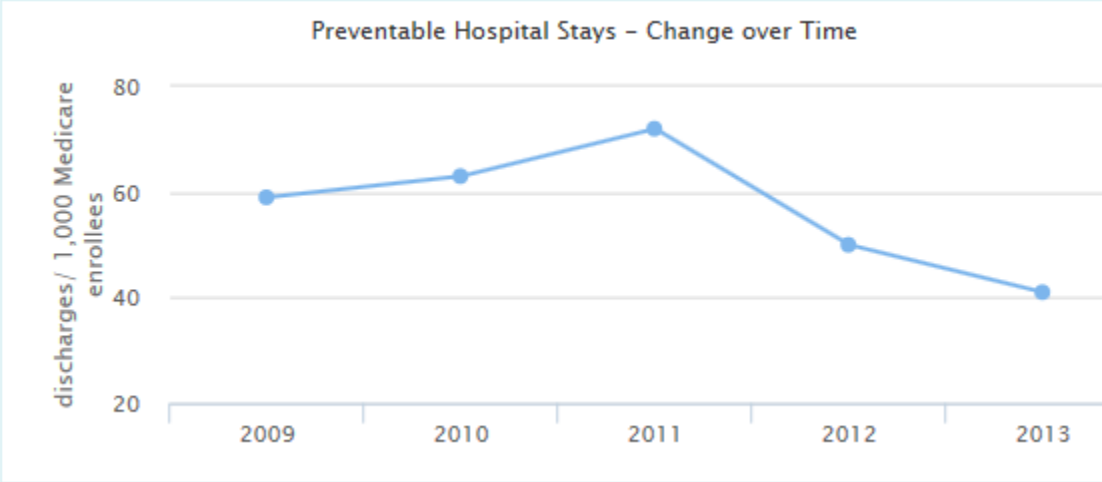
PWC



Manassas City



Manassas Park City



Diabetes

Indicator	PWC	MC	MPC	VA
% Adult s 20+ with diabetes	7.9% (2013)	8.2% (2013)	7.9% (2013)	9.5% (2013)
Age adjusted diabetes death rate	16.4 (2013)	2.0 (2013)	37.1 (2013)	18.3 (2013)
Age adjusted hospitalization due to diabetes	15.0 (per 10,000 population (2013)	16.1 (per 10,000 population (2013)	20.1 (per 10,000 population (2013)	18.8 (**per 10,000 population) (2013)**
Age adjusted hospitalization due to long term complications diabetes	8.3 (per 10,000 population) (2012-2014)	5.4 (per 10,000 population) (2012-2014)	12.3 (per 10,000 population) (2012-2014)	10.0 (per 10,000 population) (2012-2014)
Age adjusted hospitalization due to short term complications of diabetes	5.9 (per 10,000 population) (2012-2014)	10.5 (per 10,000 population) (2012-2014)	7.8 (per 10,000 population) (2012-2014)	7.4 (per 10,000 population) (2012-2014)
Diabetic screening in Medicare population	85.3% (2013)	94.7% (2013)	85.3% (2013)	87.0% (2013)

Coronary and Vascular Disease

Indicator	PWC	MC	MPC	VA
Age adjusted rate hospitalization for heart failure	33.3 (per 10,000 population 18+) (2012-2014)	23.9 (per 10,000 population 18+) (2012-2014)	24.7 (per 10,000 population 18+) (2012-2014)	35.4 (per 10,000 population 18+) (2012-2014)
Age adjusted rate Hospitalization for HTN	3.2 (per 10,000 population 18+) (2012-2014)	4.6 (per 10,000 population 18+) (2012-2014)	No data	5.0 (per 10,000 population 18+) (2012-2014)
Stroke rate in Medicare population	3.4% (2014)	3.5% (2014)	No data	3.5% (2014)

Respiratory Conditions

Indicator	PWC	MC	MPC	VA
Age adjusted hospitalization rate due to asthma	9.2 (per 10,000 2012-2014)	5.2 (per 10,000 2012-2014)	4.5 (per 10,000 2012-2014)	9.6 (per 10,000 2012-2014)
Age adjusted hospitalization rate due to COPD	15.1 (per 10,000 18+ 2012-2014)	14.7 (per 10,000 18+ 2012-2014)	13.7 (per 10,000 18+ 2012-2014)	20.2 (per 10,000 18+ 2012-2014)

Highlights

- The community now has three locations for the Greater Prince William Community Health Center, which is a Federally Qualified Health Center (FQHC). These health centers provide healthcare to both insured and uninsured residents. The uninsured are cared for based upon a sliding scale.
- The Prince William Area Free Clinic is now open five days a week compared to previously being open one night a week in Manassas and Woodbridge. Eligible clients are seen for acute and ongoing chronic issues. Presently, the clinic is only in the Woodbridge area, providing some difficulty for those on the west end of the community and limited access to transportation.
- Mason and Partners Clinic (MAP Clinic) a bridge care facility opened in the Manassas Park Community Center. This clinic provides primary and pediatric care on a walk in basis for those that are uninsured. The clinic also helps clients with navigation of the

local healthcare system, and has been successful in getting over 60% of their clients into more permanent healthcare homes.

- In Manassas Park City, diabetes is a significant chronic disease issue that needs to be addressed.
- Although the stroke rate in Medicare patients is better than the state, it has increased in the district. This could indicate uncontrolled hypertension in that target population.

Next Steps: Development of the Community Health Improvement Plan

The 2016 Health Check Survey was distributed through various venues throughout the community. The purpose was to have residents assist in identifying in their opinion, the most pressing public health problems in the community in which they live. Nine hundred and eighteen surveys were analyzed. In addition, each coalition member provided a list of community partners to send out a leadership survey, and requested that the respondent identify in their opinion important community public health problems. Fifty-two respondents completed this survey. There were two Town Hall meetings, one on May 24, 2016 at the Northern Virginia Community College in Manassas, and one on June 6, 2016 at Sentara Northern Virginia Medical Center, in order to obtain community input regarding the survey results. These meetings provided important qualitative information and robust community needs discussions.

IDENTIFIED COMMUNITY HEALTH NEEDS

Analysis of the qualitative and quantitative data from the surveys and Town Hall meetings identified public health issues that were important to the community. When prioritizing the community needs, the coalition took into consideration whether through a facilitated community effort the coalition could impact the health concerns.

When the coalition analyzed the Leadership and Health Check survey data, the top ten priority public health issues were very similar. Additionally, some of the issues were felt to be related, and could be addressed together.

The three categories of public health needs identified were:

- Substance Use/Abuse and Mental Health Conditions
- Obesity, Access to Healthy Foods, and Physical Activity
- Access to Healthcare (included dental care)

The coalition broke up into three groups to address each category by involving other knowledgeable community partners and analyzing primary and secondary data from various sources in order to better understand community strengths, weaknesses, gaps, trends, and target populations that can impact these identified health priorities.

The primary and secondary data collected for the 2016 Community Health Assessment will be used to help develop the Community Health Improvement Plan (CHIP). The Community Healthcare Coalition of Greater Prince William will take the lead in the creation and implementation of the CHIP. Program implementation will undergo continuous evaluation and ongoing quality improvement processes. This document will require community input and involvement in order to develop appropriate goals, objectives, an action steps to improve outcomes for these complex public issues.

vdhweb.vdh.virginia.gov/ofhs/CHI/

Attachments

1. Health Check Survey
2. 2016 Health Check Survey Open-ended Comments
3. Health Check Survey Top 10 Comparison 2013 with 2016 Results
4. Leadership Survey and Results
5. Community Health Assessment 2016 Leadership Survey Open-ended Comments
6. Community Healthcare Coalition of Greater Prince William Charter
7. Town Hall Flyer – English
8. Town Hall Flyer - Spanish

Attachment 1

The Community Healthcare Coalition of Greater Prince William (CHCGPW) wants to hear from you about what you think are the greatest issues of public health concern in your community! CHCGPW is a partnership between George Mason University, the Greater Prince William Community Health Center, Novant Health Prince William Medical Center, Potomac Health Foundation, the Prince William Health District and Sentara Northern Virginia Medical Center with the goal of collectively improving the health of the residents of the jurisdictions served by the participating entities. Your answers will help provide a better picture of what the community feels are some of the most significant public health issues impacting the residents where you live. CHCGPW will use your feedback to develop strategies to improve the health of our communities.

All responses will be completely anonymous. If you have any questions about the survey, please email chcgpw@mli.gmu.edu.

1. **Please provide the zip code where you live**. __ __ __ __ __

2. **Select the 5 top concerns that impact your community.**

- ☐ Access to healthy foods
- ☐ Aging issues
- ☐ Alcohol use/abuse
- ☐ Air pollution
- ☐ Availability of health care within your community
- ☐ Bullying
- ☐ Cancer
- ☐ Child abuse/neglect
- ☐ Cost of healthcare
- ☐ Dental care
- ☐ Diabetes
- ☐ Disability issues
- ☐ Distracted driving
- ☐ Domestic violence
- ☐ Drug use/abuse
- ☐ Elder abuse/neglect
- ☐ Family planning
- ☐ Gang involvement
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Homicide
- ☐ Infant death
- ☐ Infectious diseases (TB, hepatitis, etc.)
- ☐ Influenza
- ☐ Lack of exercise
- ☐ Lyme disease
- ☐ Mental health issues
- ☐ Motor vehicle accidents
- ☐ Not getting "shots" to prevent disease
- ☐ Obesity (adult, child)
- ☐ Prenatal (pregnancy) healthcare
- ☐ Racism
- ☐ Respiratory/lung disease
- ☐ Restaurant food safety
- ☐ School graduation rates
- ☐ Swimming pool safety
- ☐ Suicide
- ☐ Tobacco use
- ☐ West Nile virus/mosquitoes
- ☐ Other (please specify): _____

3. Please rate how strongly you agree with the following statements as they relate to you.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The quality of life in my community is good.	☐	☐	☐	☐	☐
Overall, I live in a healthy community.	☐	☐	☐	☐	☐
I am able to get the healthcare that I need.	☐	☐	☐	☐	☐
I must travel outside of my community for healthcare.	☐	☐	☐	☐	☐
Healthcare is of good quality in my community.	☐	☐	☐	☐	☐
My community is a good place to raise children. (Consider education, safety, child care, youth programs, etc.)	☐	☐	☐	☐	☐
My community is a good place to grow old. (Consider housing, transportation, social	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
support, etc.)					
My community provides good job opportunities.	☐	☐	☐	☐	☐
Children receive high quality education in my community (Consider public, private, and home schooling.)	☐	☐	☐	☐	☐
Housing is affordable in my community.	☐	☐	☐	☐	☐
I am prepared for a public health emergency, such as a flu pandemic or an anthrax attack.	☐	☐	☐	☐	☐
My community is safe. (Consider lighting, criminal activities, etc.)	☐	☐	☐	☐	☐
My community offers enough space for recreation. (Consider parks, indoor facilities, etc.)	☐	☐	☐	☐	☐
I prefer to live in a home where smoking inside is not allowed.	☐	☐	☐	☐	☐

4 . Approximately how long is your daily commute time from home to work?

- ○ Less than 30 minutes
- ○ 30-60 minutes
- ○ Between 1 and 2 hours
- ○ 2 hours or more

- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

5. How do you feel about your overall health?

- ○ Excellent

6. Within the last 12 months, I have received health care services through (check all that apply):

- ☐ Community Health Center
- ☐ Free Clinic
- ☐ Urgent Care Center
- ☐ Retail Health Clinics (i.e. CVS, Walmart)
- ☐ Emergency Room
- ☐ Telemedicine
- ☐ Health Department

7. If you did use any of the services noted in Question 6, why did you do so? (check all that apply):

☐ I had a true emergency. ☐ My regular doctor's office was closed or could not see me. ☐ I do not have a regular medical doctor. ☐ I could not afford services at a private medical doctor. ☐ I do not have insurance.

☐ Other (please specify): _____

_____

8. If you received health care outside of the community where you live, check the choice that best matches why:

○ My doctor of choice does not practice in my community.

○ My insurance only covers doctors outside of my community.

○ I could not get in to see a doctor in my community.

○ I could not receive specialty care in my community.

○ Not applicable

○ Other:

_____

9. When was the last time you saw a primary care provider (PCP) (e.g. internal medicine, gynecology, general practice, or family practice)?

○ Within the past year

○ 1 to 2 years ago

○ 3 to 5 years ago

○ More than 5 years ago

○ I do not have a PCP

10. When was the last time you saw a dentist?

○ Within the past year

○ 1 to 2 years ago

○ 3 to 5 years ago

○ More than 5 years ago

11. When was the last time you had a preventive health service (physical exam, blood pressure check, Pap smear, mammogram, colonoscopy, prostate exam, diabetes or cholesterol test)?

○ Within the past year

○ 1 to 2 years ago

○ 3 to 5 years ago

○ More than 5 years ago

12. If you have children have you taken them to a doctor within the last year?

○ Yes ○ No ○ I do not have children

13. Current Gender Identity:

○ Male ○ Female

○ Transgender

○ Do not identify as male, female or transgender

14. Age:

○ 18 or under

○ 19-25

○ 26-39

○ 40-54

○ 55-64

○ 65 or older

15. Ethnicity

- ○ Not Hispanic/Latino
- ○ Hispanic/Latino

16. Racial group(s) you identify with (Check all that apply.):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Other (please specify): _____

17. What language do you mostly speak at home:

_____
_____

18. Household size (including you):

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

19. Your highest level of education:

- ○ Less than high school
- ○ High school diploma/GED
- ○ Associate's degree
- ○ College degree
- ○ Graduate degree

20. Household income (if known):

- ○ Less than $10,000 per year
- ○ $10,000 to $24,999 per year
- ○ $25,000 to $49,999 per year
- ○ $50,000 to $99,999 per year

- $100,000 or greater per year
- Prefer not to answer

21. How do you pay for your healthcare?

- No insurance (pay out of pocket)
- Health insurance through employer (or spouse/ family member's employer)
- Purchase private health insurance
- Medicaid or FAMIS
- Medicare
- TRICARE
- Affordable Care Act/ Health Reform

22. Do you have comments about our 2013 community health needs assessment?

_____
_____
_____
_____
_____
_____
_____

Attachment 2

2016 Health Check Survey Open-ended Comments

Access and Cost of Care

- accessible mental health services
- Funding and more services for survivors of traumatic brain injury survivors would greatly benefit the community.
- It is almost impossible to locate affordable counseling services locally. I have to go to Alexandria to see a professional because local providers are not taking new patients.
- The Latino community has real challenges in finding affordable health care, particularly for their infants. Many pediatricians' offices will not take a new Medicaid patient unless the newborn was born on the date they were assigned to be on call for newborns. Fewer pediatricians are affiliated with the community hospitals, relying on hospitalist to cover their patients. This leads to less continuity in care.
- I have no problem accessing healthcare. I am concerned for those with minimal or no insurance who face long waits or emergency room visits to access care. The cost for them in lost time is astronomical. These are often people who have no paid sick time from work. I think the care is available just hard to access for some.
- I have health insurance can't always pay the co pay so I just end up at the ER
- Needs access to Prenatal care for all Pregnant women.
- no inpatient Mental health facility for Children in this area
- I am fortunate to have healthcare through my husband's employer, financial means to access healthy foods, and live in a safe neighborhood with access to trails and playgrounds. Many of the clients I serve in my role as a CSB counselor are disadvantaged in these areas. I believe it would be greatly helpful if Prince William County invested in more rec centers and safe places for youth in the disadvantaged areas to gather after school and during school breaks. Additional health clinics with access to mental health providers would also be beneficial. Finally, families in the County (even wealthy families) need more education on current drug trends among youth and preventative/protective factors.
- This community is seriously lacking funding for mental health care for which the needs in this community are growing faster than we can keep up. Those who need these services are often placed on wait lists for up to a year because we don't have enough resources to serve them. The same is true for medical care for those who don't have the ability to pay for any insurance.

- I am fortunate to have health insurance and am able to keep up with my medical and dental needs. However, I work with a population of people who have a lower economic status and they frequently opt not to attend to some of their basic needs because of a lack of insurance. What I see the most is that the cost of housing is so high, that people are not able to afford to support themselves and/or their children and have to live in a basement or with parents. I have had more homeless Clients in the past year than I have ever had before. If they cannot afford their basic needs, they are not going to go to a Dr. until it is absolutely necessary.

- I think there is a big need of more affordable healthcare services for those who dont have insurance. Many people struggle because they don't have the money for it.

- It would be helpful to have more information available to residents of free health care clinics and/or local health fairs for all residents to particiate and learn about a variety of resources to get and stay healthy for all children and adults of any age.

- There needs to be more help for dental and for people with no insurance.

- There is not an urgent care clinic in PWC, the clinic is in Fairfax county which borders PWC. Its not one in Dale City

- Only that they not put too much work for when we apply for healthcare for kids

- the cost of health care is not appropriate because doctors only spend five minutes with you at the visit.

- It is ridiculous how much the OBGYN charges, they charged me 485$ for a five minute exam.

- there should be a minimum time amount associated with the cost of a visit

- more help for people without insurance

- more access to low cost appointments

- We need a health center

- It is necessary that this person be from our community, that they have a good health clinic and health insurance

- I am a social worker for a health system and a huge barrier to accessing healthcare is the lack of affordable transportation. When patients are sick, weak, contagious, poor, sometimes non English speaking, using the bus system is not realistic. Having the only Free clinic on the far east side of PWC is not helpful if you live in the far west side such as Haymarket/Bull Run. Finding someone to take you to the Free Clinic means asking them to take a day off of work when you add transport time and wait times. Because patients can not get to the clinic they become sicker and sicker, then end up using the ER in crisis. Non compliance is often perpetuated by the lack of transportation. I attend many community meetings and this is a recurrent concern. Those who have Medicaid can call Logisticare and arrange medical taxi, wc van or ambulance, many Medicaid consumers complain they are not reliable, often no show or late, this delays care and also can not be set up unless 5 business days prior to appointment time. If you have an urgent

need for an unexpected appointment they have no option and often call 911. PWC is geographically one of the largest counties in the Commonwealth we need either 2 Free Clinics or one centrally located. Think out of the box, contract with Uber for a contracted rate for those who qualify for a round trip voucher to a medical appointment. There must be a solution.

- Yes make healthcare affordable for single parent.

- I feel that in the rural parts of the community, there could be better access to certain healthcare needs. For example, open-heart surgery or cardiac angioplasty is only available at Inova or Richmond, VA. Therefore, many community residents have to travel sometimes more than an hour to visit loved ones in hospitals that are far away. Stroke/Neuro care is also another specialty that is not easily accessible to the more rural parts of the community. If it were possible, there could be a more local, community hospital that would be able to support those that need acute, critical care in an emergency.

- Strongly encourage community residents to have an annual wellness exam that is typically covered by insurances, many people do not even know this is available to them at no cost.

- The large need to support teens with depression and other anxiety issues has grown to an alarming rate, and there does not appear to be enough caregivers or facilities to meet this growing population.

- Not sure I am getting best heart care

- I have insurance through my employer now, but wonder if I don't have this job, or any other job for any reason, what will happen if I don't qualify for MEDICARE, due to my age.

- Health care if very expensive if we have to get on our own.

- we need more outpatient clinic where we can see Dr's for non urgent cases so cost is kept down.

- We need to stop people coming to ER for non urgent care.

- Our area has no breastfeeding friendly pediatricians. Ever office has formula ads. Forget about breastfeeding knowlegable peds.

- Homebirth midwives are not covered.

- Discourage visit to ER , FOR NON EMERGENT CASES

- More mental health help

- Yes, When and how a lot of people with no mame has to wait for Help

- If I cant get the tax credit and pay the premium. Hope it helps the one that don't fit in the normal categories not eligible for SSI but still to sick to really be employed but still have to be in order to survive.

- I think we focus way too much on health care. We also pay too much. We pay insurers, and approvers and mouse clickers. If we actually paid doctors and nurses and not infinitely growing pool of bureaucrats, we'd all be more able to pay for healthcare. I am doing my part by participating and paying a ridiculous sum of money for services my family never needs. This survey and all of those agencies of do-gooders listed on the front are part of the problem. Stop making "healthcare" a thing that politicians care about. When its the thing people care about, we might get back on the right track. I work in education--it's equally polluted by talkers and way short on doers.

- generally my health care needs are well met. Health care needs (particularly related to mental health and substance abuse assessment and treatment needs) for low income are shamefully inadequate.

- It would be nice to have a variety of Doctors in the area that accept all different types of insurances.

- Mental health for youth is growing, and the number of healthcare providers or options to seek treatment is failing to grow at the rate of society.

- I have many friends that they do not have any medical insurance, and sometime they cannot afford high expense in medical issues. Many of them prefer not to see a doctor even that they need it.

- I work in the Health Care field, and a lot of our patients are in need of mental health appointments. It is VERY frustrating that immediate help is NOT available to them!!!!! These people need help and they can not be placed on a waiting list- or just "sent" over to the ER for help. This lack of mental health care is very scary and MUST be addressed sooner than later; or we will have a disaster on or hands!

- I think the community needs more traveling clinics to help those not able to get to treatment and or buses to treatment .

- I want to know how we can better serve our Pediatric population in this community now that Sentara Northern Virginia no longer has a pediatric unit. Working in the hospital, I see so many non-critical pediatric patients having to be transported to Inova Fairfax Hospital because we cannot admit them here, especially during cold months with flu or RSV. Thank you

- I need to see a dentist but can't due to lack of dental insurance for myself.

- Glad you are looking into this subject. My highest cost each month is the supplemental insurance I need to support Medicare and insurance for my 23 year old college student daughter and her baby. The baby's father gets insurance through his work but spends nearly $200 each month for dental insurance. Seems like we have plenty of coverage but not fully. We have no

dental or vision insurance. I pay for those services. Not everyone can pay so they go without. My son has bought just enough health insurance to avoid penalty at tax time.

- health care service donot have any pharmacy in our community

- Lack of access to mental health providers in the community was identified as an issue. How was this concern addressed? What is the current status of accessing mental health providers in the Greater Prince William community?

- I think the healthcare sector at this community is not well-prepared.

- And are there geriatricians in this area? I'll have to check this out.

- Dental care needs to become more affordable, we need some sort of free dental care place for low income individuals.

- Cost of health care premiums is TOO HIGH. Three forths of my check goes to pay health care premiums. I work for health insurance. This needs to change.

- We need a whole lot more services for the mentally ill and chemically dependent. We have no Psychiatric hospital in this community. The closest one is Novant who does not take children. Beyond that we have North Springs and Dominion for kids. The stigma for mental illness needs to stop and our elected officials can help this. They vote down measures that would provide new or increase existing mental health services every time it comes up. The ECO law in VA only changed when a legislature's son died. For years "regular" people were dying by suicide and no changes were made. But let it happen to a legislature's son and the laws are changed immediately. I'm glad the law changed but it is sad that so many regular people had to die prior to that. The school board finally named a school after Kyle Wilson the only fire fighter in Prince William County and it took over 7 years to get a school named after him. This is a disgrace and a slap in the face to fire fighters. A police officer was killed in the line of duty (in an accident he caused) after Kyle died and a school was named after him almost immediately. VA is behind on a whole host of things. Mental Health, however is the behind the most. The attitude of law makers and our representatives as well as the general public is behind the times. I came from NYS and NY is in a far better place for mental health services and chemical dependency.

- I have insurance through my employer, however, my 28-year-old daughter who lives with me cannot afford insurance under Obama's "Affordable???" Healthcare Act. She has been unemployed for 2-1/2 years now. She has learning disabilities within the autism spectrum, depression & anxiety disorder, which makes it very difficult for her to hold a job for any length of time. Virginia does not consider her to have a disability for lack of records--no medical records because she can't afford insurance, and I can't afford to pay for her. The only records I have regarding her learning disabilities are her assessments from 5th grade. I'm a widow and living on a very limited income. I pay out of pocket when something absolutely necessary comes up, but you are treated with suspect and like a common criminal when you tell someone you don't have insurance. If she were to get a job, then Mr. Obama would like to punish her with a substantial monetary penalty--which makes a lot of sense when you can't afford the

insurance to begin with. Thank you Mr. Obummer for your Unaffordable Care Act and the stigma that goes with not being able to participate. This is probably the biggest Community Health Concern that our community faces--If you aren't poor enough or disabled enough, you are forced to pay into an overpriced plan and get absolutely nothing in return (the deductibles are outrageous on top of the expensive monthly premiums!) It's Obama's kick in the butt to middle class and lower middle class. Only rich liberal democrats think he's done us a favor because it doesn't affect them and now they feel their consciences are clear because everyone has healthcare, don't they?

- We need care for the indigent population, and once they have care, a way to continue that care, preventative medicine, and making their medications available to them.

- Even people who have insurance cannot always afford their medications, we need conscientious medical providers who take the time to prescribe the medications the patient will afford, not the latest and greatest on the market.

- we need a stronger preventative medicine educational programs for the masses, in more than one language. "

- Insurance should cover OT visits with diagnosis as SPD (sensory processing disorder) especially in children. Insurance used to cover part of it. Now basic plan insurance companies do not cover it at all any more due to cuts.

- More sensory brain activity play input for all children should be available for a reasonable price that people can afford.

- I truly believe the biggest issue facing this community is health care for the uninsured and the under insured. There is NO community healthcare on the western end of the county and going to the free clinic is a HUGE challenge especially if the individual does not have a car. Going to the free clinic basically encompasses a whole day and a major challenge. Also the cost of healthcare for the uninsured or the underinsured and the elderly is a major issue. MANY elderly and low income families have to chose between medications and food. This is a crime....

- urgent care service closer to home

Built Environment

- It would be great to have more parks, trails, etc. available.

- We also need restaurants and fast food places to cook a little more healthier and less oily.

- I wish Prince William County was more competitive providing services to its citizens, parks for the community, sidewalks on the streets that way people who cannot afford to pay a gym can walk. Hopefuly the medical services (hospital, clinics and private doctors) become more competitive and reliable so that people do not have to go outside of the county for medical services.

- More community events and spaces like trails and parks which are geared towards outdoor activities like running, biking and hiking would introduce new extracurricular options besides sitting inside and watching TV.

- Community rental bikes would be a great way for people to get around.

- Congested roads like Liberia Ave do not allow a friendly environment for pedestrians, cyclists, or children playing.

- Litter found in parks, roads and schools does not inspire confidence in the maintenance of the parks equipment/structures. Litter can create hazardous health conditions for anyone but is especially dangerous to young children.

- Wide spaces in Byrd Park seem to be reserved for baseball/softball games that are not advertised amongst the community in which the majority of local children play in. The surrounding community should be considered greatly as they are primary stakeholders. Water fountains closer to these wide spaces do not have operating water fountains.

- Healthier communities have an abundance of fitness opportunities, such as activities at parks, community centers, bicycling lanes are definitely needed in Prince William county. More people would bike for leisure, exercise and bike to work if we have suitable infrastructure to support cycling in our communities.

- In Haymarket there is not enough sidewalks. There really needs to be a foot bridge from the Novant Health Haymarket hospital to the shopping center with the Khols and Walmart. Safer sidewalks would encourage healthier lifestyles for people. As of right now it is not safe for anyone near the Haymarket hospial to get to the local shopping centers. Safe walking promotes healthy lifestyles.

- The services for public transportation in Fauquier and Prince William Counties could be improved. Especially in Fauquier county where there does not appear to be a good transit system for commuters. It would be very nice t have a buses that could transport commuters, and a dream would be to have a metro stop. The roads are filled to capacity with drivers, and the more congested they become the less people have of time and quality of life since their time is spent in the car.

- Community needs greater access to trails, sidewalks, and other means to improve walkability and multimodal transportation and exercise lack of bus transportation is important issue for aging adults and those without means to drive. Bus service should be provided to town of Occoquan. Fairfax does a great job of providing transportation and parks as well as trail connections. I would like to see this emulated in Prince William.

- Easy access to gyms or places to work out. Cheaper gyms

- MORE TRAILS AND WALKWAYS BY THE ROADSIDE WILL ENCOURAGE PEOPLE TO WALK AND EXERCISE MORE GYMS

Comments Regarding CHCGPW Member Organizations

- Novant Health needs a stronger identity within the community. We don't really know what it has to offer or the good things it is doing. You may be advertising to the wealthy- but does anyone else know about the quality of services? What outreach are you doing? How involved are you in the community- the schools?

- I live in an affluent community and people here have lots of options for health care. Most will continue to travel to Fairfax especially for specialty care. Novant is not going to be able to attract the same quality of providers that Inova does. So important that Novant strive to hire the best and brightest, find ways to retain them, and pay them well.

- Sentara hospital has problems that continue. I feel better going to a hospital farther away.

- Also the better Kaiser doctors are farther away.

- I FEEL LIKE THE COMMUNITY HOSPITALS SHOULD OFFER MUCH MORE EDUCATIONAL PROGRAMS THAN THEY CURRENTLY DO.PROGRAMS SUCH AS WEIGHT LOSS/EXERCISE/DIET/NUTRITION, DIABETES EDUCATION, DRUG/ALCOHOL ABUSE, HEALTH FAIRS, HEART ATTACK AFTERCARE. IT WOULD BE VERY HELPFUL IN MY COMMUNITY.

- great place helped me out a lot financially not having insurance (GPCHC).

- I just wish that the information for free clinic for referrals etc. would be known better. I know there are a lot of resources but I had to do a lot of research to find out the information.

- The newly built Haymarket hospital advertises a well baby nursery! How do we even start children on a lifetime of health if we spend money on a resource designed to void best practices like rooming in?

General Community Issues/Concerns

- Manassas is becoming way too violent in the schools and community, especially George Town South area, please do something about that! Bullying in the Manassas City public schools is terrible, if I could afford private school or to move I would! I would like to homeschool part time but the School Board makes it very difficult to do so! Thank you!

- I believe that our government needs to concentrate on the legal citizens and veterans in this country for both health care and education. We are biting off more than we can chew and the health and education of our young are now in dire trouble. Until we face the real issues without trying to drown people out because of political correctness, the issues with our health care and education systems will continue to build as our health care and education fails our country.

- We are disconnected from each other. Instead of looking at specific diseases you need to look at the social impact of our lonely disjointed society. Too many people feel disenfranchised. You need to create community gardens, social meeting places to combat isolation, and mobile programs to reach out and connect. People who are battling to stay in a home aren't going to care about blood pressure checks or dental needs. Loneliness and isolation are public health problems

- Advertisement of any extracurricular activities outside of government/school programs are absolutely non-existent for seniors, adults and children. Therefore, it can only be assumed that activities are not available.

- Need some type of newpaper to get information out to people about what happens in our community, such as health fairs and any type of activity that would be the community. Communication and Education a must for US !!!!

- Distracted driving is a huge issue in the community. The number of people I have viewed driving and texting is deplorable. Aggressive driving to simply get a car ahead and risks that drivers take create unsafe driving for others on the road.

- JOB opportunities need to be given

- discourage mom or family to have so many children and collect money on their behalf and misuse that money, NOT USE ACTUALLY ON THEIR CHILDREN

- Play Therapies for children overcoming abuse.

- We need programs for continuing education adults in a high school program, also for childrens' programs that qualify such as dance class, gym classes, and every type of sport.

- This area cost of living is too expensive to stay after retirement

- More domestic violence help and for single mothers

- I do think that all parks should be monitored by police to ensure that no teen or adult is doing drugs or smoking around our children. Transportation should get better due to not everyone has a car to drive around.

- Suicide and domestic violence have gotten so far out of control it's sickening. Prince William County's mental health services are still in the dark ages. Very sad people are hurting and lost with no where to turn :-(

- I would suggest hosting health festivals in which the community could be exposed to all resources available ranging from health clinics to active-lifestyle activities.

- Heroin is on the rise in our area, it is concerning.

- Texting and driving is extremely unsafe, safe guards need to be instituted.

- needs programs to assist with child safety needs such as car seat for infants and childrens supplies

- We need a kids safety town like the one in Portsmouth VA. I lived there for a long time and went to the place when I was a kid.

- Focus on community awareness, engage local healthcare workers and offer volunteering opportunities to help our community

- Texting and driving has become a huge issue, as people spend more time concerned with what is on their phones than what lies ahead for them on the roads.

- We overlook the severity of tobacco use given that 33,000 people die per annum in US of tobacco related problems.

- Gun violence is also a deep concern.

- Alcoholism in the homeless community is rampant. CSB needs to take the lead on outreach to these people.

- Transportation in the future is a concern of mine. I still drive, at age 78, but what happens when I can no longer drive? All my doctors (except for one) are in Manassas. Most of my outside activities also (bowling, using the library, exercise classes at Manassas Park Community Center, church, etc.). When at some point I become unable to drive, then what? Do I have to move to a residence where transportation is provided? It costs a LOT to live in a good retirement facility. And that might be outside this area, thereby seriously decreasing my access to other activities that I now enjoy. I could afford taxis for short trips in Manassas, but what about visiting my daughter in Chantilly or my son in Fredericksburg?

- Looking forward and attempting to plan for retirement, finding affordable retirement communities in Prince William County is extremely challenging. As a single person, even with a fairly good retirement income, the houses for the most part start at or around $300,000...It would be a stretch for me and I'm sure there are plenty of other hard working folks in this county who are looking to move to more affordable areas outside the county. A shame to lose good long standing citizens of Prince William to other places where housing is more reasonable.

- Drug Abuse and dependence is getting very rampant and concerning

- How do we trust advice on vaccines and antibiotics from pediatricans with waiting rooms filled with doll baby bottles and coupons for free formula?

- The one need that I see in the Manassas part of PWC is for a homeless day center.

- There are churches that provide some serves. However there is no one place where concerned citizens can take or sent a homeless person to have basic needs met and begin to connect with help.

- The Serve Shelter is frequently full with a waiting list for single adults.

- And a person has to be ready to commit, which is difficult for many.

- The homeless have multiple illness and problems that they cannot address until basic needs are met and they know someone cares. Intellectual and Developmental Disabilities, Social Isolation, poor support, low literacy and skills, Addiction, Mental Health, and other physical illnesses are the short list. When combined with no place to shower, get laundry done, make and receive phone calls, and have a healthy meal how can they begin to work their way out of the hole called homelessness.

- An excellent example is The Lamb Center in Fairfax, VA to see a model of churches banding together to meet the need.

- My neighborhood is nice, and working people surround the area, however I work at the Hospital and I encounter alot of drug/alchol abuse paients coming in for treatment. This concerns me because drugs are in the community and excessive drinking.

- Very nice and showed where the focus of programs needs to be. More programs need to focus on heart disease awareness and prevention. Also providing funding to small non-profits established to help members of the community.

- The county needs much better care for elders with dementia. The adult daycare is so far south from Haymarket how can one expect a loved one to ride a bus or get driven to Woodbridge. It is unacceptable and social services(APS) is of NO help when called for assistance. They don't want to get involved and pass it off as a family matter. Meals on wheels should be an option even for people that can still drive occasionally when they are having a good day but on most days they aren't and cannot drive. I offered to pay double but was told since one parent has dementia and didn't drive they were eligible but since they other parent did drive they were not eligible. It is a shame. It forces elders out on the road that should not be out unless they actually feel well enough to safely drive. The cost of dementia care is outrageous and the average family cannot afford to have someone quit work to care for their elders so they are left to chance and our community needs to be much more proactive.

Comments/ Recommendations for the Survey

- I would have liked to prioritize the health care needs. Suggest next survey allows this level of prioritization.

- Survey tool assumes that all needs are weighted equally.

- I am glad you are doing this with GMU researchers. I hope Dr. Maddox is involved.

- The health insurance question does not allow for the possibility of more than one source of health insurance. It should be changed to "Mark all that apply".

- DENTAL SERVICES SHOULD ALSO BE LISTED AS A CONCERN CHOICE.

- While I have the resources for health care there are many in PWC that do not and probably won't be reached by this survey. Please consider someway to get their input.

- I think the question about whether I had taken my children to the doctor in the past year should say ""children at home"" because although I have children, they are grown. If they were still home and under age I would have brought them to the doctor in past year. Because of the way the question is worded I had to answer no or I have no children. I chose no as I do have (grown) children. This does not give you an accurate picture.

- Also I think the commute question should be average of drivers in home not just me. Mine is short , my husbands is long. I only answered for myself as the question requested.

- This survey is important to get a better idea of how the residents in Prince William and the surrounding communities are doing. I'm interested in elder care issues as I'll be retiring within the next 10 years from the local system.

- hope you're able to use other venues for this assessment-community outreach, HOA, libraries, assisted living, homeless facilities, shopping centers, etc.

- I feel like this was a good length assessment, not too long not too short. I appreciate that this is an effort headed by multiple organizations. One question that I wish was asked, and for you to analyze, is asking if people know the difference between when to go to urgent care and when to go to the ER and when you can just wait to go see you PCP for benign, acute onset of symptoms. THAT will show how health educated our county is.

- Need to be able to check more in first are limited to 5 does not allow for clear picture of community

- Need to do more frequently. Instead of once every two or three years.

- In section about community, questions should have a "not applicable" choice for those retired and those who do not have school-aged children.

- Doesn't ask what services you seek outside the community.

- Doesn't ask about multiple issues and whether you could find or now of community services :If you were facing a mental health issue, would you feel comfortable seeking care in the county? If you were facing a cancer prognosis/health issue, are there resources in the community that immediately come to mind that would assist you in the medical/health needs that are required to address this? Are you able to afford/acquire/shop for/ enjoy foods that are unprocessed or locally grown? Do you feel that there are obesity issues, if so, are these related to -personal choice - lack of food and nutrition options - family/work schedule - access to healthy food - lack of funds to obtain healthy foods – other

- Doesn't ask what health issues you and your immediate family are facing..

- What are the top 3 to 5 sports or exercise activities in which you or your family participate in the community?

- List the first 5 that you think of : non-profit agencies in your community, health services in your community, doctor/dentist/offices in your community

- This was a very nebulous and weak evaluation of what is happening in our community...

- the language barrier, I do not speak spanish .....

- There were no real health care topics included. Survey is too generalized on asked for demographic info.

- survey too long
- How do you define "community" for this survey? My geographical community is Nokesville bus Manassas is 7-8 miles away with all of its resources.
- Some of these questions should have ""N/A"" as answers. For example, my commute is actually 0 minutes because I do not work away from home. In fact, I am a homeschooling mother who does not have a paid job.

- Please consider that some of the people who answer these questionnaires do not work outside the home.

- Also, it seems a little ridiculous that you have as an answer for gender ""do not identify as male or female"". Why don't you ask if people have two X's or an X and a Y for their gender. It would be less confusing. People cannot decide to be NOT a male NOR a female. You are one or the other. That is the way we are made.

- If this is a healthcare needs questionnaire, why would you ask questions about air pollution, swimming pool safety, distracted driving, bulling and restaurant safety? Those questions pertain to environmental and community safety needs not health needs.
- The survey should be asking what we think of the health care that we get meaning the quality of the Dr;s advice and the amount of time we get to spend with the Dr. Most Dr's ae time constrained so you get little time to really talk issues. It is in and get out as the next person is in line. We have created a system in the US for health care that is not patient centric but cost centric meaning we the insurance companies etc will only pay for a limited amount of time with a Dr. In essence the patient does not receive the true focus he or she needs. Really not a good system unless you are trying to week out the population hoping that a goodly number will either not go to the Dr or die.

- Yes. Why did you ask a question about my commuting time and not give me the option of saying "NO COMMUTE"? I am retired and do not commute, but your question forced me to lie. I do not commute any longer. I put down "30 minutes or less" but it's not true.

Attachment 3

Changes in Top Ten Concerns, 2016 vs. 2013

Change	Public Health Topic	2016 Rank	2013 Rank
up	Drug Use/ Abuse	2	4
	Mental Health Issues	4	6
	Distracted Driving	5	10
	Availability of health care	7	
same	Cost of Healthcare	1	1
	Lack of Exercise	8	8
down	Obesity	3	2
	Access to healthy foods	6	3
	Alcohol use/abuse	9	8
	Dental Care	10	7

Attachment 4

Community Healthcare Coalition of Greater Prince William

Improving the health of the residents of the Greater Prince William Area

Dear Community Leader:

The Community Healthcare Coalition of Greater Prince William (CHCGPW) is currently conducting an assessment of the health needs in the communities we serve. We would appreciate your participation in this assessment by completing a brief four question survey.

This survey will assist us by identifying the most critical health problems in our area and the community services that may need to be strengthened. In addition, it is an opportunity for you to share your ideas and suggestions that would help the CHCGPW and its members achieve our mission of *working collectively to improve the health of our community by utilizing limited resources most efficiently and effectively*.

The survey will be administered on behalf of the CHCGPW by George Mason University's Center for Discovery Science and Health Informatics. Your responses will be combined with those of other survey respondents. Your name will be kept confidential. The survey information will be analyzed with other data for a comprehensive community health needs assessment for our area. When complete, the assessment results will be made available to you and will be posted on our individual organizational websites.

On behalf of the Community Healthcare Coalition of Greater Prince William, thank you for contributing to this important effort. Please click **NEXT** to begin!

Sincerely,
Dr. Alison Ansher
Chair, The Community Healthcare Coalition of Greater Prince William
District Director, Prince William Health District

Prince William Health District
SENTARA HEALTHCARE
GEORGE MASON UNIVERSITY
Greater Prince William Community Health Center
Potomac Health Foundation
NOVANT HEALTH
UVA HEALTH SYSTEM

About the Community Healthcare Coalition of Greater Prince William

CHCGPW is a partnership between George Mason University, the Greater Prince William Community Health Center, Novant Health UVA Health System, Potomac Health Foundation, the Prince William Health District and Sentara Healthcare with the goal of collectively improving the health of the residents of the jurisdictions served by the participating entities. CHCGPW will use your feedback to develop strategies to improve the health of our communities

The survey is hosted by GMU Center for Discovery Science and Health Informatics. There are 13 questions in this survey

Contact Information

Please provide contact information to assure completeness of your survey responses. Your name will not be used in any publication or public presentation resulting from this survey.

We are asking for your contact information only to assure completeness of your survey response. Your name will not be used in any publication or public presentation of the survey results.

Your name:

Your organization:

Your position title:

Your telephone number:

Your email address:

What are the important health and wellness problems impacting your community?

Please choose all that apply:

- ☐ **Access to Healthy Foods**
- ☐ **Aging Issues**
- ☐ **Alcohol Use/Abuse**
- ☐ **Air Pollution**
- ☐ **Availability of Health Care within Greater Prince William County**
- ☐ **Alzhemier's Disease**
- ☐ **Asthma**
- ☐ **Autism**
- ☐ **Bullying**
- ☐ **Cancer**
- ☐ **Child Abuse/Neglect**
- ☐ **Chronic Pain**
- ☐ **Cost of Healthcare**
- ☐ **Dental Care/Oral Health**
- ☐ **Diabetes**
- ☐ **Disability Issues –Intellectual/Developmental**
- ☐ **Disability Issues – Physical**
- ☐ **Distracted Driving**
- ☐ **Domestic Violence**
- ☐ **Environmental Quality**

☐ **Elder Abuse/Neglect**

☐ **Family Planning**

☐ **Gang Involvement**

☐ **Heart Disease**

☐ **High Blood Pressure**

☐ **HIV/AIDS**

☐ **Infant and Child Health**

☐ **Homicide**

☐ **Infant Death**

☐ **Infectious Diseases (TB, Hepatitis, etc.)**

☐ **Influenza**

☐ **Injuries**

☐ **Lack of Exercise**

☐ **Lyme Disease**

☐ **Mental Health Conditions**

☐ **Motor Vehicle Accidents**

☐ **Not Getting "Shots" to Prevent Disease**

☐ **Neurological Disorders (Seizures, Multiple Sclerosis)**

☐ **Obesity (Adult, Child)**

☐ **Orthopedic Problems**

☐ **Prenatal & Pregnancy Care**

☐ **Racism**

☐ **Renal (kidney) Disease**

☐ **Respiratory/Lung Disease (other than asthma)** **Restaurant Food Safety**

☐ **School Graduation Rates**

☐ **Sexually Transmitted Disease**

☐ **Swimming Pool Safety**

☐ **Stroke**

☐ **Substance Abuse – Illegal Drugs**

☐ **Substance Abuse – Prescription Drugs**

☐ **Suicide**

☐ **Teen Pregnancy**

☐ **Tobacco Use**

☐ **West Nile Virus/Mosquitos**

Other: _____

Community Health Services in Need of Strengthening

The following is an alphabetical list of health services typical of most communities. Please check each service which you think needs strengthening in terms of AVAILABILITY, ACCESS, or QUALITY. If you are not sure about an item, just skip it and move on to the next one. Also use the space at the end to tell us about any additional services in need of strengthening which are not on the list:

Which community health services need strengthening?

Please choose all that apply:

☐ **Aging Services**

☐ **Behavioral Health Services (including mental health, substance abuse and intellectual disability) Cancer Services (screening, diagnosis, treatment)**

☐ **Chronic Pain Management Services**

☐ **Chronic Disease Services (including screening and early detection) Dental Care/Oral Health Services**

☐ **Domestic Violence Services**

☐ **Early Intervention Service for Children**

☐ **Environmental Health Services**

☐ **Family Planning Services**

☐ **Food Safety Net (food bank, community gardens) Health Care Coverage**

☐ **Health Promotion and Prevention Services**

☐ **Home Health Services Homeless Services Hospice Services**

☐ **Hospital Services (including emergency, inpatient and outpatient) Job/Vocational Retraining**

☐ **Long Term Care Services**

☐ **Maternal, Infant & Child Health Services**

☐ **Patient Self Management Services(e.g. nutrition, exercise, taking medication)**

☐ **Pharmacy Services**

☐ **Physical Rehabilitation Primary Health Care Services Public Health Services**

☐ **School Health Services**

☐ **Social Services**

☐ **Specialty Medical Care (e.g. cardiologist, oncologist, etc.) Transportation**

☐ **Workplace Health and Safety Services**

Other: _____

Additional Ideas or Suggestions

The mission of the Community Healthcare Coalition of Greater Prince William is to work collectively to improve the health of our community by utilizing limited resources most efficiently and effectively. At your opinion, please use the space below to share any additional ideas or suggestions which could help the Community Healthcare Coalition and its member organizations achieve its missions.

Please write your answer here:

Request for input on selected health priorities

In 2013, Novant Prince William Medical Center and Sentara Northern Virginia Medical Center conducted their last community health needs assessment. The published studies may be found at the links provided below. Please provide in the space below any input you might have on the previously selected health priorities in the space provided.

Links to published 2013 Community Health Needs Assessment Studies

Novant Prince William Medical Center:
https://www.novanthealth.org/Portals/92/novant_health/documents/about_us/community/NHPWMC_CBIP_FINAL.pdf

Sentara Northern Virginia Medical Center:
http://www.sentara.com/Assets/Pdf/Locations/Hospitals/Community-Health-Needs-Assessments/SNVMC-2013.pdf

Obesity

Diabetes

Cancer

Uninsured/Underinsured

Behavioral Health/Emotional Well Being

Thank you for your contribution to this community health study effort.

Dr. Alison Ansher

Chair, The Community Healthcare Coalition of Greater Prince William
District Director, Prince William Health District

Submit your survey.

Thank you for completing this survey.

Attachment 5

Community Health Assessment 2016 Leader Survey – Open-ended Comments

1. **What are the important health and wellness problems impacting your community?**
   - Health care for children and families not eligible for Medicaid or medical insurance
   - Virtually all of the above, at least to some degree. It is a reflection on the problems or American society. Some problems would vary I could only guess. I hope that I am not going to be called upon to try to prioritize this laundry list on frequency or prioritization.
   - Travel shots available
   - Homelessness
   - Access to healthcare

2. **Which community health services need strengthening?**
   - All of these are likely candidates for improvements in our society. Rather than writing a treatise. Missing from this list is the most pervasive problem, one that attenuates many to most of these problem areas. This is lack of the central strength of our families. Single parent and dysfunctional families are an underlying problem for socieity's inability to deal with many of it's problems.
   - Pediatric Concussion Care

3. **The mission of the Community Healthcare Coalition of Greater Prince William is to work collectively to improve the health of our community by utilizing limited resources most efficiently and effectively. At your opinion, please use the space below to share any additional ideas or suggestions which could help the Community Healthcare Coalition and its member organizations achieve its missions.**
   - Healthcare options and health insurance availability for families within PWC and the state of VA is a concern. Families who are not able to afford Marketplace insurance are left with minimal options. Continued partnership with local health care providers and health insurance companies are necessary to increase family access to appropriate and necessary health care.

   - Childhood obesity rates within the Head Start program are concerning and are addressed through parental education, encouragement of increased physical activity, and nutritious meal options in school. Approximately 23 percent of Head Start children are obese and another 17 percent are considered overweight for their age.

   - Affordable and accessible mental health services is a need in our community. Costly prescription costs are also a concern.

- Manassas Park has no grocery stores. Many of our clients "shop" at 711. In addition our seniors social security income makes them ineligible for SNAP benefits. They need supplemental food from food banks.

- Ongoing collaboration between community partners is essential in order to create and provide outreach to this community. Parental education surrounding health care is crucial to our first generation children. I believe we should strengthen our dental outreach and school nurses should be informed of medicaid participating providers.

- Food insecurity in our community continues to be a challenge and education surrounding nutrition is essential for the prevention of obesity.

- As a non-profit we understand the need for more funding or the use of efficiently using the means provided. We have learned to assist our clients as best as we can with limited resources. Having a larger collaboration with partners that can provide different services would be beneficial to our community. Having a central collaborating agency to assist all the providers would make a great impact. Many of the resources are sporadic and the search for who provides what is limited. Having a peer navigator/agency to assist providers with reaching out and participating in collaborative, committees or other councils which work to assess the community needs would be very effective in addressing the gaps in resources.

- Many of the issues faced by people in the community center around mental health problems. We have very few resources for managing behavioral health emergencies and long term treatment.

- We still have a working poor who cant afford a nutritional diet (apples are over $1 each!) and lack appropriate health care. The ACA is not affordable for many individuals and small business in the county.

- Expanded free health clinic sites.

- Free legal services

- Free immigration services

- I think there are some difficult hard facts regarding the many, many problems that exist in our society. Too many for all of them to be handled with equal priorities of funding and effort. I'll note that virtually each of these problems in today's society seems to have its own growing public constituency that each wants it to get a larger share of this necessarily limited store of resources. So we are necessarily headed for an administration of this increasingly stalemated effort as, for example, it exists in the State of California.

First, I suggest that first dealing with these above hard facts is a priority before the aforementioned stalemate is upon us (as it nearly is.

Secondly, we do have a problem for helping those in society that are in genuine crisis and this is a priority. More screeners are needed to see those in need of mental health problems earlier. Those involved with drugs are a separate and needed area.

Third, a more effective triage process for those in the flow of those screened and found in need of help to maximize use of our resources.

Finally, as stated above, we need make efforts to heal the truncated family structures in our society to make them more resilient and capable of dealing with each other's problems and vicissitude's.

- The medical system needs more primary care and longer paid for primary care appointments. By utilizing primary care services and allowing the providers enough time with each patient, the cost of each patient's care can be greatly reduced. It does not make sense to send every patient with chest pain to a cardiologist for a full expensive work-up if the real cause for their chest pain is anxiety related to home or work stress. Doing three CT's of the abdomen for one patient each year, does not help if the true cause of their abdominal pain is constipation. Enabling the providers the time to spend with each patient to provide the appropriate evaluation and education may be the best and cheapest options for many patients. Hospital follow-ups are critical to ensure unnecessary readmissions. This also depends on the primary care provider having enough time to review all the records, educate the patient, ensure the appropriate medications, and follow-up labs, radiology, and consults are ordered.

- There is a desperate need for pediatric concussion care on the eastern half of Prince William County. Right now, there are no places to take children who have been concussed in our community. The nearest locations are Manassas and Fairfax.

- It would be best for us to have a better process for peer navigation for services within the partners.

- Difficult to know if a difference has been made by community efforts.

- HAVE MORE AFFORDABLE MEDICAL SERVICES. WE ONLY HAVE THE MOSS FREE CLINIC IN OUR AREA AND IT IS VERY HARD FOR CLIENTS TO GET IN TO BE SEEN BY A DR. YOU HAVE TO ARRIVE AT 5:30 IN THE MORNING TO GET IN LINE AND HOPE TO BE SEEN. DENTISTRY IS A BIG PROBLEM IN OUR AREA OUR WORKING POOR CLIENTS CANNOT AFFORD DENTAL CARE FOR THEMSELVES OR THEIR FAMILY MEMBERS.

- We need to impact the stigma that Mental Health issues have on our community. We need to increase outpatient as well as in patient Mental Health Services in our community. There is only one psychiatric hospital in this community and that one only takes adult patients. There is only one in patient substance abuse provider in the community. As the county/state closes psychiatric beds they take that money away and do not put it into out patient services. We should explore the options other states such as NY especially in the upstate NY area (Buffalo, Rochester, Syracuse). We have a long way to go in the way we provide services to consumers of mental health and substance abuse services in our community.

- Try to pick out the services especially Mental Health and Drug addiction start there.

- The availability of hospice in a small environment is non existent. I have worked previously in an area where there were hospice homes that served two patients at a time and also provided patient families with lodging so that families could be with their loved ones. My husband and I did ten years as volunteers in such an environment in Fairport, New York called Advent House.

- I retired from Social Security, 27 years of which were in the Manassas, VA office. I have always been concerned with the issues of homelessness, mental health, and nursing home abuse and fraud (mostly by family members) in our area. I have spoken with many social workers and nursing home administrators over the years and know that most do the best they can, but because the demand is so great and with limited staffing so many in our community fall through the cracks. I believe education is a major plus, but only if it gets to the ones who most need it and can understand it. Too many don't have any idea of what resources are available or how to go about finding them.

- Use of telemedicine for behavioral health

- larger network for the coalition to include Rotary, Lions, etc

- We don't have a volunteer base to do the grassroots efforts

- The mental health crisis is impacting our inpatient hospital. Pt's suffering from mental illness end up in the ED and there are no beds at facilities. These patients tie up many resources in order that we keep them safe, and we are not a primary psychiatric facility.

- Alcohol and homelessness is same type of problem. Patients get admitted to detox, regardless of their desire to stop drinking. There need to be more resources for substance abuse treatment programs.

- Elder care and elder and family care provider resources

- Indigent care resources

- Will there ever be adequate resources? I think that there will never be enough money and suggest removing the word "limited" - all resources are limited.

- We need to integrate our entire delivery system from hospitals, providers and community based organizations. We miss an opportunity every time we work in silos. There should be a community eligibility process that is simple and transfers to all service providers. We could reduce costs and improve outcomes.

- I recently learned of three health fairs within one week of each other. I would like to see more collaboration and partnering to get residents to have the means to travel to attend one large community health fair. By having separate fairs with many of the same exhibitors you can save each organization's personnel time and money to attend just one large fair!

- Create a community fund or an angel fund to help support research and development of diseases.

- Affordable clinics and basic care being met can prevent further more complications of more advanced diseases.

- Working collaboratively with multiple groups can prevent duplication and serve the maximum numbers of people

- More responsibility should be expected from the members of the community to make better life style choices and take responsibility for poor choices they have made. Counsel and advise should be available if requested as to making better decisions and how to best recover and/or adjust from a lifetime of making poor choices when it comes to our health.

- Our community is fortunate to have many alternate healthcare choices and opportunities.

- Would like to see an improved access to care by partnering with local hospitals and health department. Undocumented immigrants, women and children are vulnerable groups for health care.

- the biggest gap i see in pw is in having specialists in our service area to address specific needs

4. In 2013, Novant Prince William Medical Center and Sentara Northern Virginia Medical Center conducted their last community health needs assessment. Please provide in the space below any input you might have on the previously selected health priorities in the space provided.

Obesity

- Childhood obesity rates within the Head Start program are concerning and are addressed through parental education, encouragement of increased physical activity, and nutritious meal options in school. Approximately 23 percent of Head Start children are obese and another 17 percent are considered overweight for their age.
- Need more walking paths.
- Nutritional Education and the need for exercise, particularly for children.
- if fitness centers and gyms could give a reduce rate or even free membership for people with chronic diseases such as diabetes and HTN, with no insurance,
- All of these areas are still a concern for the community.
- I'm not presently aware of any county-wide public health/health promotion initiatives around this issue.
- Maybe off some kind at the office of Social services
- Courage FUN project with Courage Soccer to combat obesity - workbooks include content for the parents and the children
- Obesity and chronic pain medication/abuse.
- Develop community based coaching strategies that assist families in learning about and participating in good nutrition and simple exercise plans.
- Epidemic
- This was popular at the time.
- Focus on behavioral health counselors helping the obese population understand the difference between mindless eating and mindful eating.
- This focus helped me more than any diet I tried in my 58 years!
- Remains a major concern; Starts with children
- This starts in the schools with education about healthy diet, exercise and providing ONLY healthy options
- agree this is a growing long-term health issue

Diabetes

- Physicians can be a good resource and advocatefor patients to engage in classes for diabetic education.
- if diabetes educational classes were free
- As you know diabetes is one of the greatest self care illnesses. The patients need to be educated and motivated to provide healthy self-care. Assess to excellent primary care with non-rushed providers is critical to ensure that the patients know what to do at home to prevent unnecessary long term problems such as heart disease, kidney disease, stroke, amputation, and blindness.
- ALOT OF OUR CUSTOMERS CANNOT AFFORD THEIR MEDICINE
- There seems to be a need for additional culturally competent and multi-lingual interventions and treatment opportunities for Diabetes in PWC.

- Maybe off some kind at the office of Social services
- Due to the increased number of children with diabetes, I think there needs to be more education on this issue and more emphasis placed on helping families who have children diagnosed with diabetes understand the consequences of non-compliance with prescribed treatment.
- PHF grants for diabetes and pre-diabetes have identified more person with pre- or diabetes and have initiated education for them
- non-compliance of diabetic patients.
- See very sick, obese patients with diabetes who are relatively young all the time
- A real issue that needs prevention attention.
- Develop community based coaching strategies that assist families in learning about and participating in good nutrition and simple exercise plans.
- Teaching people to try to avoid diabetes by long term choices is critical!
- County could use increased Type 1 resources. Type 2 is tied to Obesity and life style concerns (lack of exercise)
- Improved screening

Cancer

- Early screening education
- Screening is critical. Access to timely care when something is found is also critical. The uninsured who are not already in a free clinic setting, are delayed while becoming financially eligible.
- OUR CLIENTS CANNOT AFFORD DR. VISITS TO GET THE EARLY DETECTION TESTS DONE
- Not only cancer but there is not sufficient specialty care available within the County. Given the proximity to other major health institutions in DC/Northern Virginia I wonder what level is actually needed or expected in PWC?
- Maybe off some kind at the office of Social services
- need for more hospice/palliative care.
- Always
- Declining
- Screening
- Glad NOVANT bought out the Fauquier Hospital partnership of Cancer center. Much easier to promote and fundraise in community since PW area really did all the support from it's inception.
- Continued screening and support services like hospice

Uninsured/Underinsured

- Healthcare options and health insurance availability for families within PWC and the state of VA is a concern. Families who are not able to afford Marketplace insurance are left with minimal options. Continued partnership with local health care providers and health insurance companies are necessary to increase family access to appropriate and necessary health care.

- We have clients who are not eligible for Medicaid but can't afford the Affordable Health Care premiums.
- There is a need for parents to be informed of options for their children in regards to insurance. The immigrant population is very afraid of applying for benefits for their children.
  In our school division we have begun to incorporate education surrounding benefit eligibility at our monthly Family Market.
- Adults between the ages of 19 and 65 are no currently eligible for Full Coverage Medicaid in Virginia unless they are disabled, blind or pregnant. When applying for health insurance through the federal marketplace individuals whose income is under the Medicaid limit will be sent back to the local social services office for coverage. The only coverage available is limited to family planning known as Plan First. This coverage is limited to an annual pap screening and birth control and some other minimal services.
- Over the past several years, I have noticed a great increase in the severity of illnesses of our patients, all of which are uninsured and low-income. They require extensive primary care, medications, lab and radiology testing, and specialty referrals. Transportation to receive all of these services is also an issue. The patients also seem to have less money to aid with any portion of their care even if it is only a few dollars. Obtaining funding for the clinic to be able to provide the needed care continues to be an issue even with the great kindness of so many donors, medical and non medical volunteers, specialists, and in-kind donations of medications, laboratory, radiology, ER, in and out patient services.
- The majority of our clients are uninsured or cannot pay their co-payments.
- THE WORKING POOR POPULATION IN OUR AREA HAVE A VERY HARD TIME FINDING AFFORDABLE HEALTH INSURANCE
- Seems to be little additional able to be done until Virginia would elect to expand Medicaid.
- Maybe off some kind at the office of Social services
- While there have been significant strides made in health services for uninsured/underinsured, there needs to be more services available for this population to help them access services and to find ways to obtain health insurance that is affordable.
- Makes transferring of the patient difficult if they need long term care or rehab services.
- Huge gap for this population
  State of Va turning down funding simply makes no sense
- Will always be an issue, even if there is Medicaid expansion.
- We need to work together to reach out to the uninsured. There are not enough resources available. With all the urgent cares, hopefully strain is being taken off emergency rooms now.
- High Charity Care impacts service providers. Use of Emergency Room for non emergency cases drives costs into system
- How to improve access to care

Behavioral Health/Emotional Well Being

- Lack of mental health services especially for children who receive Medicaid or who do not have insurance

- Access to mental health counseling and prescription drugs.
- Very much a critical need across all ages. Not enough providers.
- About 1/3rd of our patients have some form of mental illness. About 7 years ago, after starting an on-site mental health program that partners with the already on-site medical program, a great difference could be seen in how quickly the patients start feeling better both physically and emotionally. A patient who is having both their physical and mental health needs met is so much better able to do all the healthy life style activities that we encourage them to do as well as take care of their chronic illnesses. Patients with mental health issues also require additional time when being seen by their primary care provider also.
- There are not enough services for our homeless clients.
- I have huge input in the Behavioral Health arena.
- Seem to be some advancement on related care for youth/adolescents but additional are needed for both insured/uninsured adults and seniors.
- Maybe off some kind at the office of Social services
- Due to the increased number of students seen with mental health issues and the increased number of suicides, access to mental health services is greatly needed. There also needs to be more mental health providers available for children with mental health issues.
- Need more access to the inpatient behavioral health facilities. Need quicker access to psychiatrists to see pts in the ED.
- Huge need
- This is a critical need that underlies many problems such as homelessness.
- Integrate this into primary care. We do not have enough resources!
- Never enough experts in this arena to help support the demand.
- Mental Health is a challenging issue in our world today
- Community services needed at low cost

Attachment 6

Community Healthcare Coalition of Greater Prince William

Improving the health of the residents of the Greater Prince William Area

Community Healthcare Coalition of Greater Prince William Charter

June 2015

Version Control

Version #	Implemented By	Revision Date	Approved By	Approval Date	Reason
1.0	CHCGPW	06/08/15	CHCGPW	06/08/15	
	CHCGPW	April 2016	CHCGPW	April 2016	Added Kaiser Permanente to

Table of Contents

I. Purpose

This charter is a statement of the scope, objectives and participants in the Community Healthcare Coalition of Greater Prince William (CHCGPW). It outlines the mission of the CHCGPW, identifies stakeholders and provides a preliminary delineation of roles and responsibilities.

The purpose of the CHCGPW is to bring together a multiagency and multidisciplinary group of entities and individuals to develop a sustainable dashboard of community health indicators (CHI) that represents the work of the coalition, and to use existing recognized platforms to identify and prioritize community health issues, conduct a community health assessment, and plan, implement and evaluate a community health improvement process. The Coalition will also be responsible for identifying ways limited, applicable resources can be used most efficiently and effectively.

II. Vision and Mission

Vision: Greater Prince William Area is a community of healthy people.

Mission: The Community Healthcare Coalition of Greater Prince William will work collectively to improve the health of our community by utilizing limited resources most efficiently and effectively.

III. Goal

The goal of the CHCGPW is to collectively improve the health of the residents of the Greater Prince William Area and jurisdictions served by the participating entities.

The goal of the Coalition to improve the health of the community will be accomplished by:

- Use of a shared dashboard as a robust source of secondary data
- Collection of comprehensive primary data to support interpretation of secondary data and enhance the quality of community health assessments
- Prioritization of community health needs
- Coordination of comprehensive implementation strategies to maximize impact on specific health needs and priority communities
- Evaluation of implemented strategies and institution of quality improvement initiatives as needed
- Mobilization of expertise, resources, effective skills-based health education, and accountability for community health outcomes
- Establishment of stronger relationships and partnerships between the hospitals, community health center, Health District, George Mason University, and other members of the healthcare community
- Promotion of a safe, healthy environment, both physical and psychosocial and activities that improve access to health services

IV. Scope

The scope of the Coalition includes:

- Supporting the development and sustainment of a CHI dashboard
- Engaging community health, education officials, advocates and leaders in efforts to promote a safe, healthy environment where residents can thrive
- Developing and strengthening partnerships for a collective impact and resource sharing

V. Milestones

The Coalition's performance will be measured by fulfilling the following milestones in calendar year 1 of 2015 (January-December):

Quarter 1 (January – March)

- Identify priority health issues and outcomes of greatest concern based on previous community health assessments conducted by represented entities.
- Determine the Essential Members of the Coalition.
- Ratify the CHCGPW Coalition Charter.

Quarter 2 (July-August)

- As needed, announce Request for proposals (RFP) to identify potential shared document platform.
- Select and sign contract with CHI Dashboard vendor.

Quarter 3 (September-December)

- Develop CHI Dashboard.
- Initiate collective community health needs assessment.

Quarter 4 (January-March)

- Reevaluate implementation strategy based upon findings in the community health needs assessment.
- Establish proposed Year 2 milestones.

VI. CHCGPW Membership

Membership: Membership in the CHCGPW is open to entities or individuals that agree to work collaboratively on the development of a sustainable platform of community health indicators as well as the creation and implementation of community health improvement initiatives.

Essential Membership:

- George Mason University
- Greater Prince William Community Health Center
- Kaiser Permanente
- Novant Health (Prince William Medical Center & Haymarket Medical Center)
- Potomac Health Foundation
- Prince William Health District
- Sentara Northern Virginia Medical Center

George Mason University is a public institution and the largest research university in Virginia. George Mason is based in Fairfax County. Additional campuses are located nearby in Arlington County, Prince William County and Loudoun County. The university enrolls approximately 34,000 students, making it the largest university by head count in the Commonwealth of Virginia and is recognized for its strong programs in economics, law, creative writing, computer science and business. For additional information, please visit: https://www.gmu.edu.

The ***Greater Prince William Community Health Center*** provides primary, prenatal, dental and behavioral health care to all residents of Prince William County and the Cities of Manassas and Manassas Park regardless of age, income or insurance status. For additional information, please visit: http://gpwhealthcenter.org.

The ***Kaiser Permanente*** Community Benefit Department makes financial, material and human resource investments across the Mid-Atlantic region to directly address health care issues and eliminate health inequities in our communities. Kaiser's doctors and clinicians focus on providing quality medical care for our members. Its community benefit work is an extension of the care provided in the clinical setting. The focus is on improving the health of its members and their neighbors where they live, work and play. For additional information, please visit: https://kaiserpermanente.org.

Novant Health Prince William Medical Center provides emergency services, maternity care, surgery, pediatrics, cancer care, heart and vascular, and behavioral health services. The Medical Center also features comprehensive outpatient services in Gainesville, Haymarket, South Riding and Woodbridge. These locations include Novant Health physician practices, imaging, The Cancer Center at Lake Manassas, lab and rehabilitation. The campus in Manassas, Virginia is home to 170-beds. Located a short distance from the hospital is Caton Merchant House, Novant's assisted-living facility. For additional information, please visit: https://www.novanthealth.org/prince-william-medical-center.aspx. In early 2014, Novant opened Novant Health Haymarket Medical Center. Novant Health Haymarket Medical Center located in Haymarket, Virginia is a 60-bed, acute care hospital that also features physician offices and the Haymarket Ambulatory Surgery Center. For additional information, please visit: https://www.novanthealth.org/haymarket-medical-center.aspx.

Potomac Health Foundation is a private, independent health foundation located in Woodbridge, Virginia. It was established in December 2009 as a result of the merger between Potomac Community Hospital and Sentara Healthcare. Potomac Health Foundation serves the communities in eastern Prince William County, Virginia and adjacent communities in southeast Fairfax and north Stafford Counties. Potomac Health Foundation is a grantmaking organization that focuses on promoting wellness and preventing disease. It does not provide health services directly to consumers, but it does offer financial support to tax-deductible organizations that do. Potomac Health Foundation is governed by an all-volunteer Board of Directors comprised of civic leaders and health specialists from the region. They are dedicated and caring members of the community

who wish to promote healthy outcomes for all persons and healthy communities throughout our area. For additional information, please visit: http://potomachealthfoundation.org.

The ***Prince William Health District (PWHD)*** operates multiple programs to protect and improve the health and well-being of its residents. Services provided include: immunizations; high risk and routine maternity care; environmental health services, including restaurant and pool inspections; family planning services; confidential diagnosis, treatment, and counseling for sexually transmitted diseases; tuberculin testing and diagnostic chest x-rays; confidential HIV testing and early intervention services; nutritional education and food vouchers for women, infants, and children (WIC) clients; processing of birth and death certificates, and investigation of reportable diseases. Services are provided at several different locations throughout Prince William County, and the

independent cities of Manassas and Manassas Park. For additional information, please visit: http://www.vdh.state.va.us/lhd/princewilliam/.

Sentara Northern Virginia Medical Center is a 183-bed hospital located in Woodbridge, Virginia. Sentara provides comprehensive, quality clinical services, including advanced imaging, lab services, cardiovascular, emergency care, vascular and weight loss. Sentara primarily serves residents of Prince William County, but also Fairfax County (Lorton and Springfield), Stafford and Alexandria. For additional information, please visit: http://www.sentara.com/Northern-Virginia/Pages/Home.aspx.

Membership Responsibilities/Expectations:

Members of the CHCGPW will designate a representative and an alternate to ensure ongoing participation in the CHCGPW. Representatives should:

- Be individuals with decision-making authority
- Attend regularly scheduled meetings.
- Participate in establishing priorities for the GPWHCC
- Educate and inform member organizations on GPWHCC activities
- Respect the opinions of others

VII. Team Norms

In order to maintain a productive, collaborative environment, members agree to the following team norms:

- Be open minded
- Ask for clarification if you do not understand
- Expect and respect differences of opinion
- Give and receive feedback positively
- Focus on the assessment and the process
- Equal participation using your strengths
- Meetings limited to set time determined by the team

- Consensus with agreement to abide by the decision of the majority
- Be respectful of team members' time, start on time and end on time

VIII. CHCGPW Roles

Chairperson: The Essential Members shall elect a Chair of the CHCGPW who will be responsible for facilitating the meetings. The Chair shall also work with CHCGPW members to promote collaboration. The term of office for the Chair shall be 2 years.

Vice-Chair: The Vice-Chair shall perform the duties of the Chairperson in their absence. The Vice-Chair shall assume the position of the Chair at the conclusion of the Chair's term.

Election of Chairs: Election of the Chair shall take place every 2 years, or as necessary to fill a vacancy, the Essential Members shall elect a new Vice-Chair. Elections shall be held in February. Terms shall take effect March 1.

Committees: The four fundamental committees include: Administrative, CHI Dashboard Development, Finance, and Funding Opportunities. The Essential Membership may create additional committees as it deems necessary to conduct the business of the CHCGPW.

Note Taker: The Note Taker is responsible for taking minutes at each meeting and preparing them for the Chair to review and approve prior to sending them to other committee members. In addition, the Note Taker will work with the Chair to develop a meeting agenda and will send the agenda with minutes in preparation of the next meeting.

Coalition Members: Coalition Members will serve as a liaison to their respective organizations and agencies regarding CHCGPW activities. Members are expected to commit to sharing responsibility in completing action steps in the timeframe determined by the CHCGPW. If a member is unable to attend a CHCGPW meeting, send another knowledgeable and informed agency or organization member to participate in the member's place.

IX. Conducting CHCGPW Business

Voting membership: Each Essential Member shall have one vote.

Quorum: A quorum is necessary to conduct the business of the GPWHCC and shall consist of those Essential Members participating in a meeting. A quorum may be achieved by Essential Members being physically present at a site or joined electronically.

Votes on Issues: Passage of issues voted on by the GPWHCC Essential Members requires one vote over fifty percent of the Essential Members participating in the meeting whether physically or electronically present.

Changes to Charter: Passage of changes to this Charter or any other organizational document requires a vote of two-thirds Essential Members.

Meetings: The CHCGPW shall hold quarterly meetings. Special meetings may be convened at the request of the CHCGPW Chair.

Notice for regular meetings shall be provided to all members at least ten working days prior to the meeting. Notice for special meeting shall be provided at least five working days prior to the meeting. Notices shall include the time, place and agenda for the meeting, and the means available to join the meeting electronically. No business at a special meeting may be transacted except as specified in the meeting notice.

The meeting agenda for regular meetings will be developed. Minutes of all meetings shall be prepared and distributed to the membership for approval.

X. Approval of the Charter

Participation in the activities of the GPWHCC constitutes assent to the terms of this charter.

Attachment 7

Community Healthcare Coalition of Greater Prince William

Improving the health of the residents of the Greater Prince William Area

2016 TOWN HALL MEETINGS

Join us to voice your opinion to improve the health of the community!

Tuesday, May 24th

5:30 – 7:30 PM

Northern Virginia Community College
Colgan Theater (Manassas Campus)

6901 Sudley Road
Manassas, VA 20109

Please park in Parking Lot B.

Monday, June 6th

5:30 – 7:30 PM

Sentara Northern Virginia Medical Center
Hylton Education Center

2300 Opitz Boulevard
Woodbridge, Virginia 22191

Please park in Visitor Entrance.

Help us create a Community Health Assessment that will identify the most significant public health challenges facing our community. Your input will assist us in developing community health improvement strategies for making positive, long-lasting changes. Be part of the conversation with other residents and community partners to help rank public health priorities and impact the future health of our community.

About the Community Healthcare Coalition of Greater Prince William (CHCGPW)

CHCGPW is a partnership between George Mason University, the Greater Prince William Community Health Center, Novant Health UVA Health System, Potomac Health Foundation, the Prince William Health District and Sentara Northern Virginia Medical Center with the goal of improving the health of the residents in our communities.

Prince William Health District · SENTARA HEALTHCARE · GEORGE MASON UNIVERSITY · Greater Prince William Community Health Center · Potomac Health Foundation · NOVANT HEALTH · UVA HEALTH SYSTEM

If you have any questions about either of the Town Hall Meetings, please email chcgpw@mli.gmu.edu.

Attachment 8

Community Healthcare Coalition of Greater Prince William

Improving the health of the residents of the Greater Prince William Area

2016 REUNION DE LA COMUNIDAD

Únase a nosotros y denos su opinion para mejorar la salud de la comunidad!!

Martes, 24 de Mayo	Lunes, 6 de Junio
5:30 – 7:30 PM	5:30 – 7:30 PM
Northern Virginia Community College Colgan Theater (Manassas Campus) 6901 Sudley Road Manassas, VA 20109	Sentara Northern Virginia Medical Center Hylton Education Center 2300 Opitz Boulevard Woodbridge, Virginia 22191
Por Favor estacionarse en el lote B.	Por favor estacionarse en la entrada para visitants.

Ayúdanos a crear una Evaluación de Salud de la Comunidad que identificará los retos más importantes de salud pública que enfrenta nuestra comunidad. Su información nos ayudará en el desarrollo de estrategias de mejora de la salud de la comunidad para hacer cambios positivos y duraderos. Sea parte de la conversación entre los residentes y socios de la comunidad para ayudar a las prioridades de salud pública e impactar la salud futura de nuestra comunidad.

Acerca de la Coalición Comunitaria de Salud de Greater Prince William (CHCGPW)

CHCGPW es una asociación entre la Universidad George Mason, la clínica Greater Prince William Community Health Center, Novant Health UVA Health System, Fundación Potomac, la clínica de Salud del distrito de Prince William y Sentara Northern Virginia Medical Center con el objetivo de mejorar la salud de los residentes en nuestras comunidades.

Si tiene alguna pregunta acerca de la reunion de la comunidad, por favor envíenos un correo electrónico a: chcgpw@mli.gmu.edu.

Prince William Health District · SENTARA HEALTHCARE · GEORGE MASON UNIVERSITY · Greater Prince William Community Health Center · Potomac Health Foundation · NOVANT HEALTH · UVA HEALTH SYSTEM

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